HOUSING AND SUPPORTS FOR PEOPLE WITH PHYSICAL DISABILITIES

April 2001

A Planning Framework for the Vancouver/Richmond Health Region

Prepared For:

Vancouver/Richmond Health Board
Working Together for Better Health

BC Housing

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Foreword

This document has been completed with significant input from many stakeholders including individuals with significant disabilities and advocates. This report clearly identifies that best practices in housing and supports must ensure flexibility, diversity, equitability, and choice.

This report recognizes that the fundamental objective is to provide housing and support options that are both based on the principle of "individualization". The choices available, and the funding available, should offer the greatest potential for direct funding, linked to the individual, to allow consumer choice and control of housing and supports.

The intent of this report is to ensure that the best practices, principles, values, goals and objectives of both housing and supports are fully recognized and integrated to the greatest extent feasible in the planning and development of additional and new housing and support resources for individuals with significant physical disabilities, including those for whom facility care is currently the only choice available.

EXECUTIVE SUMMARY

In April 2000, the Vancouver/Richmond Health Board issued the *Strategic Plan for Housing Services,* a document that provided a vision and framework for the development of housing services for individuals with high health risks. This project is a direct outcome of the *Strategic Plan* document and is being undertaken by the Health Board in partnership with BC Housing, in recognition that housing issues and support issues are inter-related and must be addressed together.

BC Housing provides affordable and accessible housing throughout the province. BC Housing's role is to work in partnership to respond to the range of needs that exist in relation to housing. Partnerships play a key role in identifying needs and solutions; this includes other levels of government, other ministries, non-profit societies and co-ops, and community-based agencies working with clients with specific housing needs.

Working Definition of Persons with Physical Disabilities

For the purposes of this report, a working definition of "persons with physical disabilities" was identified. Persons with physical disabilities whose needs are addressed in this report are individuals and families who:

- have mobility impairments that limit their housing options, and
- have housing affordability issues, and
- need support services, and
- may have other concurrent impairments such as cognitive impairment or deterioration, developmental challenges, addictions, mental illness, or head injury.

Values and Principles

1. A range of consumer choices in both housing and support options.
2. Individual integration within the community.
3. "Nothing about me without me": autonomy and self determination in housing and support.
4. The provision of supports and housing should be based on a "most facilitative" model as opposed to a "least restrictive" model, and should not be dominated by a health care paradigm.
5. Design housing to maximize independence and abilities.
6. Provide housing tenure.
7. Funding should be based on individual requirements.
8. System collaboration and continuity.

Demographic Projections

The need for housing and supports for individuals with physical disabilities will continue to grow for the following reasons:

- G.F. Strong will continue to discharge rehabilitation clients.
- The incidence of acquired disabilities such as multiple sclerosis, arthritis, strokes, and other physically disabling conditions will continue to increase with an aging population.
- Wheelchair accessible units will continue to have very low turnover rates.
- The trend of deinstitutionalization continues and residents from Pearson and other long term care settings will continue to move into the community.
- Increasing survival rates of younger adults with moderate to severe physical disabilities (Gnaedinger, 2001).
- Increasing numbers of younger adults with moderate to severe chronic illnesses and disabilities (Gnaedinger, 2001).
- Increasing numbers of individuals with disabilities who choose to live in their own community homes and need considerable supports to do so will place greater pressure on community-based services, and there will be growing demands for services as these people age. (Gnaedinger, 2001).

Current Housing Barriers and Solutions

Barriers	Solutions	Partners
Design and construction of wheelchair "adaptable" units	• Review of role and value of "adaptable" units compared with "accessible" units. • If "adaptable" units are retained, provide mechanism for adaptation when required.	BC Housing BC Housing
Design and construction of wheelchair "accessible" units	• Design guidelines should be reviewed to ensure that they meet current functional needs. • Staff training and education re. design of wheelchair accessible units. • Continue with ongoing design review to ensure compliance with guidelines. • Review of 12% capital allocation. • Mechanism for renovation and adaptation of units that are designated accessible but which are not functional.	BC Housing BC Housing housing providers architects and builders Disability organizations BC Housing BC Housing BC Housing in partnership with consumers, housing providers and funding agencies.
Lack of links between those in need of housing and those providing housing	• Awareness and education initiatives directed to housing providers. • Partnership building between disability consumers, advocates and organizations and housing providers and housing organizations. • Awareness, access and utilization of online housing registry.	Consumers, advocates and disability organizations with support from BC Housing, and directed toward BCNPHA, CHF-BC, and housing providers. Access and utilization by disability consumers, advocates and organizations assisting individuals to find housing.
When units become available, a subsidy may not be available	• Exploration of changes to subsidy allocation models. • Education and awareness to promote subsidy availability.	Consumers, advocates and disability organizations with support from BC Housing, and directed toward BCNPHA, CHF-BC, and housing providers.

Barriers	Solutions	Partners
Location of wheelchair accessible housing	• Educate housing providers and resource groups to consider location as a criterion in the provision of wheelchair accessible units within each project.	Disability organizations, working with housing providers, resource groups and BC Housing.
Inadequate support funding	• Consider increased individualized funding.	Vancouver/Richmond Health Board
	• Consider strategies to enhance flexibility and choice within funding limitations.	Vancouver/Richmond Health Board
	• Consider a designated funding envelope for housing/support models for persons with physical disabilities.	Vancouver/Richmond Health Board
Health care system policies and practices	• Consumer involvement in the development of new options and choices.	Disability consumers, advocates and organizations working with V/RHB
	• Empowering and enabling policies appropriate to the needs and goals of people with disabilities.	Vancouver/Richmond Health Board
	• Greater flexibility and more receptivity to innovation.	Vancouver/Richmond Health Board
	• Improved co-operation and collaboration between Ministries and agencies. Formal strategies to develop better linkages and continuity, such as committees and working groups.	The Ministry of Health, V/RHB, Ministry for Children and Families, Ministry for Social Development and Economic Security, and BC Housing, advocacy and consumer organizations.
	• Improved communication of information and models of housing and supports.	V/RHB BC Housing

Barriers	Solutions	Partners
Lack of transition opportunities	• Incorporate the concept of transition into all planning for housing and support options. • Consider formalizing transition opportunities within currently available models of housing and support. • Consider transition needs in the development of new housing and support options. • Provide funding for transitional programming and resources.	G.F. Strong, George Pearson Centre, other rehabilitation and long term care facilities, organizations which provide transitional supports, peer supports, advocacy, and skills development.

Current Models of Housing and Support Options

The following section provides an overview of a continuum of current housing and support options for individuals with physical disabilities who require access to both supports and affordable, accessible housing.

The continuum varies along two dimensions: the type of housing provided and the model of supports. This section describes five models of housing and four models of supports, and how they can be offered in different combinations to increase the range of consumer choice. The concept of transitional supports can be integrated into all of the housing and support options, based on specific and unique individual needs.

Five Models of Housing

1. Community Residence
2. Shared Home/Apartment
3. Clustered Dwellings with Shared Common Areas
4. Clustered Dwellings
5. Individual Dwellings

Four Models of Supports

1. Staffed Housing
2. Shared Supports
3. Combined Staffed/Individualized Supports
4. Individualized Supports

Housing and Support Models – Current Practices

The following table indicates how many individuals with physical disabilities currently live in these arrangements.

HOUSING MODELS	SUPPORT MODELS	NUMBER OF CLIENTS
Care Facility	• Staffed Housing	• 443 (Pearson and Long Term Care Facilities)
Community Residence	• Staffed Housing	• 24 (False Creek Residence)
Shared Home/ Apartment	• Staffed Housing	• 48 (Group Homes)
	• Shared Supports	• 6 (Creekview)
	• Combined Staffed/Individualized Supports	• None
Clustered Dwellings with Shared Common Areas	• Staffed Housing	• 10 (Steveston)
	• Shared Supports	• 7 (Noble House)
	• Combined Staffed/Individualized Supports	• None
Clustered Dwellings	• Staffed Housing	• 24 (Kelly Court and Blair Court)
	• Shared Supports	• None
	• Combined Staffed/Individualized Supports	• 6 (Bloomfield)
Individual Dwellings	• Individualized Supports	• 133

Best Practice Policies

- Self Determination
- Choice
- Flexibility
- Equitability
- Diversity
- Wellness

Housing and Supports – Implementation Plan

This report has identified a continuum of housing and support options, solutions to specific barriers, best practices in the provision of housing and supports, and specific actions required to improve and expand the range of housing and support models.

The Advisory Committee for this report has agreed to continue working collaboratively to address these issues and provide management and support for implementation of the report recommendations.

This section integrates all of these recommendations within an action plan that focuses on four areas:

1. Policy
2. Information and Awareness
3. Additional Housing and Support Capacity
4. Implementation Resources

There are a total of 14 areas for action identified, with specific implementation recommendations for each one. These recommendations for action address the issues identified in this report and move toward achieving the goals, values and principles that have been articulated. Many of these actions require leadership by various stakeholders from the Advisory Committee that contributed to this report.

The areas identified for action are:

Policy

1.0 Changing health care system policies and practices.

Information and Awareness

2.0 Disseminating this document widely.

3.0 Seeking support for the values, principles and best practice policies identified in this report.

4.0 Communicating and information sharing about housing and support options.

5.0 Building relationships between housing providers and housing consumers.

6.0 Designing guidelines for wheelchair accessible and wheelchair adaptable units.

Additional Housing and Support Capacity

7.0 Identifying housing and support needs and preferences.

8.0 Increasing funding for supports.

9.0 Adding resources for transition opportunities.

10.0 Accessing housing subsidies.

11.0 Maintaining and expanding the rent supplement program.

12.0 Targeting new BC Housing developments.

13.0 Targeting private sector housing opportunities.

Implementation Resources

14.0 Adding resources to implement the recommendations.

INTRODUCTION

In April 2000, the Vancouver/Richmond Health Board issued the *Strategic Plan for Housing Services,* a document that provided a vision and framework for the development of housing services for individuals with high health risks. This document acknowledged that the majority of housing for the disability community supported by the Health Board has been residential (group homes, facilities) in nature. The Plan emphasized the need for a fundamental shift from the more traditional emphasis on residential services to the inclusion of more independent, supported models of housing. A recommendation of the Plan was to undertake a comprehensive consultation process and identify a range of possible housing options that will maximize independence and autonomy for individuals with physical disabilities. This project is a direct outcome of the *Strategic Plan* document and is being undertaken by the Health Board in partnership with BC Housing, in recognition that housing issues and support issues are inter-related and must be addressed together.

BC Housing has fully recognized that housing "can contribute to an individual's health, safety and security, as well as promote involvement in the labour market and in the community" (Affordable Housing in British Columbia Fact Sheet). BC Housing's role is to work in partnership to respond to the range of needs that exist in relation to housing. Partnerships play a key role in identifying needs and solutions; this includes other levels of government, other ministries, non-profit societies and co-ops, and community-based agencies working with clients with specific housing needs.

In recent years, BC Housing has placed increasing emphasis on housing for populations with special needs, including homeless-at-risk, mental illness, and other disabilities. "For many British Columbians it is not enough that their housing is affordable. They also need a range of supportive services to allow them to live independently and to participate fully in their communities... In responding to the diversity of needs that exist, it is necessary to ensure that there is a range of options available." (Special Needs Housing Fact Sheet).

Working Definition of Persons with Physical Disabilities

For the purposes of this report, a working definition of "persons with physical disabilities" was identified. Persons with physical disabilities whose needs are addressed in this report are individuals and families who:

- have mobility impairments that limit their housing options, and
- have housing affordability issues, and
- need support services, and
- may have other concurrent impairments such as cognitive impairment or deterioration, developmental challenges, addictions, mental illness, or head injury.

Advisory Committee

An Advisory Committee was established to provide consultation throughout the project. The purpose of this group was:

- To identify a full continuum of inter-related housing options and support models that maximize choices and appropriately meet the needs of individuals with physical disabilities in the least restrictive manner possible.
- To make recommendations to address barriers to developing the continuum of housing and support options.
- To act as consultant in the preparation of this report.

Terms of Reference

The terms of reference for this report focused on persons with physical disabilities were:

1. To identify the values and principles underlying the planning and development of housing options and services.
2. To inventory available housing, to complete a needs analysis and to identify gaps in the range and supply of housing.
3. To identify key Best Practices for various types of housing services (supported, residential and stabilization/transitional).
4. To identify Best Practice models in B.C., Canada and other jurisdictions.
5. To identify system barriers and make recommendations with regard to addressing barriers.
6. To develop a housing framework (including a standardized nomenclature) that reflects a continuum of housing options for people with varying levels of disability.
7. To recommend a multi-year development plan and identify possible resources to address funding requirements.

VALUES AND PRINCIPLES

One of the first tasks of the project was to work with the Advisory Committee and other community stakeholders to identify and articulate the values and principles underlying the planning and development of housing options and services. (Please refer to Appendix A for the complete data.) Interviews were completed with 14 individuals who have extensive experience in the area of physical disabilities. From the interview data, key themes were identified and the interview comments were categorized into each of the theme areas. For each theme area, a statement was developed, summarizing the issues and values identified.

1. A range of consumer choices in both housing and support options.

People with disabilities should have a range of both support options and a range of housing options and should be able to make choices based on their unique and different needs. Choices should not be limited by what is available.

2. Individual integration within the community.

People with disabilities should be recognized first and foremost as citizens. Community integration constitutes more than the provision of housing and basic personal care located in the community. Integration includes the ability to participate fully in the social, recreational, educational, employment and other opportunities that provide a quality of life equal to that of a person without disabilities living in the community.

3. "Nothing about me without me": autonomy and self determination in housing and support.

People with disabilities should be respected and involved as participants in all decision making related to their lives, including housing and supports. The capacity for self-determination should be recognized. For those who need assistance with decision making, the individual should determine who will assist them, and those individuals should be enabled to support the person with a disability in decision making.

4. **The provision of supports and housing should be based on a "most facilitative" model as opposed to a "least restrictive" model, and should not be dominated by a health care paradigm.**

Housing and support choices need to be anchored on the belief that people should not have to live in residential care facilities. Of equal importance, the negative attributes of care facilities should not be transferred to housing and supports in the community. The goal should be to think first and foremost of a person's home.

5. **Design housing to maximize independence and abilities.**

Housing should be designed and built with design and technology features that promote independence and meet the needs of the widest range of people with disabilities.

6. **Provide housing tenure.**

People with disabilities should enjoy the same security of tenure as people without disabilities and housing tenure should not be dependent on supports.

7. **Funding should be based on individual requirements.**

Funding should be based on individual requirements. The specific models for the delivery of supports and housing should offer a range of choices.

8. **System collaboration and continuity.**

There is need for continuity and linkages to allow people with disabilities to move between health regions, between organizations and agencies, and to benefit from the co-operation of various government ministries and programs.

Disability Movement

The "independent living" movement emerged as a grass roots movement in the 1960's and 1970's and over the last thirty years has become firmly established as an alternative paradigm to the medical-rehabilitation model. The independent living paradigm argued that individuals with disabilities have the right to the same quality of life and same opportunities for self-actualization as the non-disabled population (DeJong, in Taylor, 1990). At that time, the two key components identified were "deinstitutionalization" and "normalization". A 1984 report stated that:

> There is a trend away from merely contributing towards the survival and maintenance of people considered quite unable to satisfy their own basic needs and defined in negative terms towards the setting up of services to help them fend for themselves and to become part of the fabric of society.[1]

These themes have continued to develop: in 1989, the "growing consumer expectations" were recognized in an internal report to the Executive Council of the British Columbia Rehabilitation Society on "Placement Problems – Housing".

Currently, the Individualized Funding project of the B.C. Coalition of People with Disabilities advocates for the individualized funding of supports required for individuals with all types of physical disabilities to allow them to live independently. "Individualized funding" refers to the provision of funding directly to the client, who has choice and control in determining how to use their funds to meet their unique and individual support requirements. The Seattle 2000 Declaration on Self-Determination & Individualized Funding established founding principles, articulated action required to support self-determination, and defined guiding principles and principles for implementation. The rationale is that the current "systems operate in ways that deny control to those they intended to serve. Without accountability to those who require their assistance, these systems decide how, where and with whom people shall live and spend their days." The current system denies people with disabilities the ability to exercise their rights or fully participate in their communities. The values emphasized include: self-determination as a birthright, elimination of barriers, recognition of capacity, flexibility, and recognition of individualized funding as valuable as an investment in people and communities.

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[1] Commission of the European Communities, The Economic Integration of the Disabled: An Analysis of Measures and Trends in Member States. Luxembourg, 1984, p. 61, cited in Placement Problems – Housing. A Report for the Executive Council of the British Columbia Rehabilitation Society, 1989.

Facility Care

The historical approach to housing and supporting people with physical disabilities has been largely limited to facility care.

George Pearson Centre is the largest care facility for people with physical disabilities in British Columbia. George Pearson Centre was opened in 1952 as a residential hospital for tuberculosis patients; in 1955 another 50 beds were opened for polio patients. It has housed more than 300 residents at peak utilization in the 1950's. In the 1970's the hospital became a specialized extended care facility for people with chronic significant physical disabilities such as spinal cord injuries, multiple sclerosis, and neuromuscular disorders. At this time, there are about 147 people living at George Pearson Centre.

Since the 1960's and 70's, individuals and their families have advocated for less institutional and more residential models of housing and support. One of the concerns at that time (and currently) was younger adults who were at risk of being inappropriately accommodated with predominantly geriatric populations because of a lack of more appropriate alternatives. Other concerns include the quality of life, the physical environment, and the relationships between staff and the individuals being supported.

Since the opening of George Pearson Centre, there have been some significant positive changes in terms of facility care:

- There have been fewer epidemics that have resulted in permanent disability.
- People with significant disabilities are living longer and healthier lives than historically.
- There has been a universal trend away from institutional support and toward community integration. This shift has occurred for people with physical disabilities, people with mental illness, and people with developmental disabilities.
- Housing and support options have evolved to provide progressively more individualized housing and supports, and to provide them to people with disabilities that were previously considered to require facility care.

Trend Toward Residential Models

In 1960, the Community Chest and Councils of the Greater Vancouver area published a report calling for the provision of affordable, accessible housing for "handicapped persons capable of independent living", and also calling for "specially designed, low-rental hostel[2] accommodation to be provided for handicapped persons of all ages who are unable to live independently." (page 4). However, at that time, "dependent living" was limited to individuals with disabilities who required "some level of self-care assistance but of a lesser degree than that provided in a nursing home". (page 9).

In 1977, the provincial Ministry of Municipal Affairs and Housing conducted a study on *Housing Needs of the Handicapped*, which identified housing needs and solutions. However, the report excluded "persons who require care in some type of officially licensed facility – whether an extended care hospital or community group home" as this population was considered to be beyond the terms of reference of provincial housing policy. (Report on Proceedings, page 6).

An early success was the development of False Creek Residence in Vancouver in 1979, which was designed for young adults with physical and developmental disabilities. The 24 bed facility was designed to be similar to a college dormitory: each resident had their own bedroom and a washroom was shared by two rooms. There were centralized bathing, laundry, social and dining areas. This licensed facility continues to provide housing and support, and when a newer building was recently developed with fully self-contained units, none of the current tenants chose to move.

Another, more recent response to the concerns about predominantly geriatric populations was the development of William Rudd House which opened in 1995 in New Westminster. This project was developed to provide a less institutional alternative for extended care clients who were being accommodated on wards in the geriatric facility. The program is specifically for individuals with physical disabilities aged 19 to 55. Located on the grounds of Queen's Park Extended Care Hospital, the 12 bed facility offers private rooms, private washrooms with showers shared between two rooms, central bathing, social and dining facilities. The design, scale, finishes and decor are more residential than institutional. The goal of the program was to provide an affordable model of residential based care.

Both of these examples could be characterized as "institutions that are more residential", and they represent one incremental shift away from facility care.

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[2] "Hostel" is defined as a dormitory or individual room with shared bathroom and laundry facilities and with communal dining and recreation room.

Another approach that was widely used during the 1970's and '80's was the development of group homes. This approach focused on the goal of community integration and of living in a "normal" family environment. Many group homes continue to operate successfully; however at this time, no new group homes are being developed. This model has become outdated as housing and support objectives continue to become progressively less institutional.

Another more recent and significant shift has been acceptance of the goal of accommodating even significantly physically disabled individuals in the community.

In the early 1980's, six young men who were all ventilator dependent due to spinal cord injury and who all lived at George Pearson Centre, determined that they wanted to live in the community. In 1985, they moved into "Creekview" a six bedroom apartment designed to accommodate their needs. The apartment was part of a large co-operative housing project in Vancouver. This project marked a turning point in establishing that people with significant physical disabilities could live independently in the community, given appropriate supports and an appropriately designed residential environment.

Following the precedents established with the development of Creekview, another group of residents at George Pearson Centre determined to also move out, but to obtain their own apartments along with a "shared care" model of support and space for shared mealtimes. This goal resulted in the development of Noble House, which opened in 1990. The 21 unit apartment building includes housing for seven adults with significant physical disabilities, including ventilator dependence. This model provided a more residential physical environment, with each tenant having a fully self-contained, private one bedroom apartment combined with shared communal space.

Both of these models demonstrate the provision of residential based housing and support. Neither Creekview nor Noble House are licensed; it is recognized that the occupants are capable of managing their own support and making lifestyle choices. Both groups directly train and manage their own staff, meal planning and budgeting.

By some measures, all of these models are considered to be institutional because of the model of support provision, which is shared among tenants and is linked to the housing. The current trend is toward residential models in which the housing and support may be separated, and in which are both completely individualized. Previous studies have noted the link between housing and supports:

In 1992, a *Housing and People with Disabilities* brief was submitted to the Provincial Commission on Housing Options. The report noted that "the process of planning for housing for people with disabilities must insure an optimum balance between lifestyle priorities and efficient delivery of supported living services".

Housing and Physical Disability

There have always been individuals with physical disabilities who did not require facility care. For these individuals the principal barrier has been the availability of accessible, affordable housing. Canada Mortgage and Housing Corporation (CMHC) was historically the federal agency responsible for the development and subsidy of affordable housing. In 1975, they began to mandate the provision of wheelchair accessible units in projects; by 1985 a policy was established that 5% of all units were to be wheelchair accessible. This mandate has continued with BC Housing, which is now responsible for the development of social housing.

The provision of wheelchair accessible units in social housing programs have successfully met the needs of many individuals with physical disabilities who either do not require supports to live independently or who have been able to secure adequate and appropriate support through Continuing Care home support and home care nursing resources.

In addition to social housing for those who require assistance in obtaining affordable housing, there have been other initiatives to enhance the availability and suitability of housing for people with physical disabilities. In 1972, the Lions Paraplegic Lodge was opened in Vancouver as the first fully accessible apartment halfway house. In 1979, a three storey apartment building with all units wheelchair accessible was constructed and operated with a shared care model. In 1982, BILD (Building Independent Living with the Disabled) was formed in Vancouver and by 1986 it had developed 14 accessible housing co-operatives providing a total of 573 housing units; 11% were wheelchair accessible.

By the mid-1980's the provision of wheelchair accessible units in social housing projects was well established with other co-operatives and development consultants also developing wheelchair accessible housing. There were 30 group homes operating in the Vancouver area, and the Creekview apartment had just been completed.

The next major step in housing and physical disability in Vancouver was the opening of Noble House in 1992.

The 1992 Provincial Commission on Housing Options recognized that "the demand for social housing for people with special needs has increased significantly over the past few years." (page 74) and recognized that the issues of housing and support are often linked. The Commission's report recommended that "The provincial government should improve co-ordination among those ministries that provide services to people with special needs. In particular, a strengthening of the links between the Ministry of Municipal Affairs, Recreation and Housing and the Ministry of Health is recommended." (page 75).

In addition to public sector housing development, there have been other developments and initiatives to promote affordable, accessible housing for people with disabilities.

In 1995, the Community Living Society undertook a public-private partnership to obtain, without public subsidy, ten units of affordable, accessible housing within a private sector condominium development in Burnaby. This model of private sector partnership without public subsidy was repeated in 1998, when Vancouver Resource Society obtained six units of accessible housing at Bloomfield Gardens, a private sector market condominium project in Vancouver.

In 1999, both St. George's Place and Millennium Place in Vancouver were opened; these developments, subsidized by BC Housing, provided wheelchair accessibility or adaptability in all of the units and included infrastructure such as electronic control systems throughout the building to automatically open doors, use the elevator and access common areas.

In 1999 the City of North Vancouver adopted Adaptable Design Guidelines which mandate a minimum level of accessibility in all new multiple unit buildings, and which provide incentives for additional provisions to enhance accessibility. Vancouver, Richmond and several other municipalities are attempting to develop similar initiatives, integrating wheelchair accessibility into all residential buildings.

In 1999, the Vancouver/Richmond Health Board completed a *Strategic Plan for Housing Services*, which noted that "the range of possible housing options for an individual [with a physical disability who requires supports] is directly related to the level of support services required. Limitations on the hours of support services available to an individual are largely driven by the availability of health care funds. In cases where the available support hours are not adequate to fully meet the needs of the individual living independently, it is necessary to look to some form of physical co-location with others to allow for a 'shared care' model."

In 2000, the False Creek Residence Society developed an integrated family housing development in Richmond, which included 10 self-contained apartments for people with significant physical disabilities, combined with common amenity spaces including a therapeutic tub, dining room and kitchen, and the provision of 24 hour supports. This model meets the needs of consumers who may not be able to participate in a shared care model because of their support requirements , and provides a residential living environment combined with the provision of adequate supports.

Provision of Supports

Some individuals with physical disabilities do not require access to supports to be able to live independently. Others, with more significant physical disabilities, require support and assistance with nearly all activities.

Until the 1970's institutional care was the only means of providing support to persons with significant physical disabilities. With the development of the first group home in 1974, less institutional models of housing and support began to emerge.

Prior to 1978, community organizations such as the Victorian Order of Nurses and Neighbourhood Houses provided home support services to elderly and disabled individuals. In 1978, the establishment of the Continuing Care program formalized community based supports to those living in the community. However, if care needs were assessed to be too great to support in the community, the only choices were institutional models, including residential staffed models, as discussed above. This generally remains the case, although the level of support provided to individuals with disabilities in the community has increased significantly compared to historically. There has been a consistent trend has been toward supporting higher levels of disability in the community and greater independence and consumer autonomy in the model of supports.

Enhanced Consumer Participation Model

In 1990, the Vancouver Health Department introduced the "Enhanced Consumer Participation Model" (ECPM) as a means of addressing concerns regarding client independence, autonomy, control and participation. Goals included quality of life, quality of service provision, and accountability to the client. This program empowered consumers and was intended as "a progressive step toward self-management" (ECPM Training Manual, page 2).

Choices in Supports for Independent Living

The initial ECPM program was the basis for developing, the Choices in Supports for Independent Living (CSIL) program, which was introduced as a pilot project in 1994. This program provided direct funding to consumers based on their assessed needs and on their ability to direct their own support. Consumers were responsible for managing all aspects of their own support. This program was developed as an alternative means of funding and delivering the Continuing Care home support services, which would otherwise be contracted through an agency. Since the initial pilot project, this program has been formally adopted and continues to grow.

Consumer Support Group

As a second phase, a similar model, termed the Consumer Support Group model, was introduced in 1997. This program is an option within the CSIL program, and provides the same opportunities for individuals who are unable to independently direct and manage their own support. A registered Society is formed with friends and family who are then responsible for managing the supports on behalf of the client. Both of these programs have expanded the opportunities for client control of supports, and provide individualized funding approaches.

DEMOGRAPHIC DATA - HOUSING AND SUPPORT NEEDS

There is limited demographic data to quantify the magnitude or type of current housing and support needs. Those with significant physical disabilities who require both affordable, accessible housing and supports comprise a relatively small population of all people with physical disabilities, and the range of needs is diverse.

Disability

The primary source of data on disability is the Statistics Canada Health and Activities Limitations Survey (HALS), which was last conducted in 1991. This data pertains to all of British Columbia. It may not accurately represent the incidence or severity of disability in the Lower Mainland as many individuals with physical disabilities move here in order to access supports and services.

Statistically, the majority of adults with physical disabilities have "mild" to "moderate" physical disabilities and are aged 50 and over. In British Columbia, the average disability rate is 16.7% of the population; this ranges from 8.2% for those 14 and under, to 44% for those 65 and over. Of those with disabilities, 18% are classified as "severe"; this represents 4% of the total population. 5% of adults with disabilities use a wheelchair. 49% have a mild disability. 59% of those with disabilities have mobility impairments and 54% have agility impairments, compared with 30% who have hearing disabilities, and 16% who have vision disabilities.

Of adults with disabilities, 2% live in care facilities; of those with moderate to severe disabilities and chronic illnesses, about 20% live in facilities rather than in the community (Gnaedinger, 2001).

Data on the Lower Mainland from one recent study (Taylor, 1996) of individuals living in wheelchair accessible social housing found that the typical occupant profile was a female, aged 41 years old, who had multiple sclerosis or a spinal cord injury, lived alone and received an average of 10.5 hours a week of assistance. The study participants ranged in age from 25 to 68. 26.5% had spinal cord injuries, 20.6% had multiple sclerosis, 17.6% had cerebral palsy, and the balance of the sample included neuromuscular disorders, post polio syndrome, rheumatoid arthritis and other disabling conditions.

Respondents used a range of mobility devices; 76% used a wheelchair all of the time. 44% used an electric wheelchair all of the time, 32% used a manual wheelchair all of the time. 12% used an electric wheelchair sometimes, and 29% sometimes used a manual wheelchair. 18% sometimes used a scooter, 12% sometimes used crutches, and 18% sometimes used a walker, canes, or leg braces.

Income

In terms of income, the average income for working age adults with disabilities was 21% lower than the average for adults without disabilities (HALS 1991) and "persons with severe disabilities tend to have lower incomes than those with mild or moderate disabilities". (*A Portrait of Persons with Disabilities*, page 60). The poverty rate for individuals with disabilities is about twice the rate for the general population (Gnaedinger, 2001), and the unemployment rate is more than twice that of the general population. Income impacts on the demand for affordable housing. For individuals with severe physical disabilities, incomes are generally equal to that provided through B.C. Benefits.

Supports

Gnaedinger (2001) identifies several issues related to the provision of supports:

- Funding – necessary for the provision of adequate and appropriate supports.
- Integration of services – services need to be integrated to be effective.
- Appropriateness of services – services must be appropriate for each client group.
- Staffing – inadequate staffing leads to increased dependence, loss of function and increased care needs. Other issues include lack of staff continuity and lack of communication. The single most critical factor in enabling persons with disabilities to achieve independence and control of their lives is attendant support (Gutman in Gnaedinger).
- Control – clients seek independence and autonomy; control over life and environment.
- Privacy – needing support compromises privacy and clients privacy must be respected.
- Need for mentoring – the role of peer support and guidance is becoming significant.
- Need for mental health services – are especially important for individuals with chronic physical disabilities who live in residential facilities.
- Analysis of services – clients may be "hard to serve" due to behaviours, unrealistic care expectations, or an inappropriate care setting.
- Evaluation of services – support services should be evaluated in terms of accessibility, availability, physical environment, information resources, interpersonal quality of client-staff exchanges, technical skills of providers, service relevance and effectiveness of services, and client satisfaction with their degree of input into decision making.

The demographic data demonstrate that the majority of individuals with physical disabilities do not have severe disabilities, and many can access a range of housing options without requiring the provision of supports or using minimal supports. Many of these individuals live in wheelchair accessible social housing units.

Data from Taylor (1996) found that while some respondents did not receive assistance, 85.3% of the respondents received support services, ranging from a median of 10.5 hours per week, up to 80.5 hours per week. The type of assistance varied with disability, and is summarized in the following table. Over half of those receiving support had assistance with personal care as well as homemaking activities.

Within the Vancouver/Richmond Health Board, there is no data on home support/home care nursing utilization by individuals with physical disabilities. There are a total of 703 individuals with physical disabilities who receive supports through formal programs, as summarized in the table on the following page.

Disability specific programs and facilities currently funded by the Vancouver/Richmond Health Board include:

# of V/RHB Funded Clients	Program	Client Profile
24	False Creek Residence	Individuals with significant physical disabilities who benefit from support with decision making.
10	False Creek Residence at Steveston	Individuals with significant physical disabilities who require access to 24 hour care; some benefit from support with decision making.
6	Creekview	Designed to accommodate significantly physically disabled adults who are able to direct their own care.
7	Noble House	Individuals who are significantly physically disabled and are able to direct their own care.
12	Blair Court	Moderately physically disabled adults who can direct their own care.
12	Kelly Court	Moderately physically disabled adults who can direct their own care.
6	Bloomfield Gardens	Moderately to severely physically disabled adults who can direct their own care.
48	Group Homes	Moderately to significantly physically disabled adults who are unable to direct their own care.
147	George Pearson Centre	Significantly physically disabled adults, many of whom have cognitive impairment and complex or deteriorating conditions.
296	Continuing Care Facilities	Individuals under the age of 65 with significant physical disabilities and cognitive impairment.
114	CSIL/CSG	Individuals who are managing their own supports through CSIL or CSG.
19	Individualized Contracts	Individuals with individualized support service contracts with the agencies funded by the V/RHB.
917	Home Support Clients	Adults (aged 19-65) living independently in the community with home support. (Excludes seniors and individuals with mental illness.)
1,618	**TOTAL**	

Demographic Projections

The need for housing and supports for individuals with physical disabilities will continue to grow for the following reasons:

- G.F. Strong will continue to discharge rehabilitation clients.
- The incidence of acquired disabilities such as multiple sclerosis, arthritis, strokes, and other physically disabling conditions will continue to increase with an aging population.
- Wheelchair accessible units will continue to have very low turnover rates.
- The trend of deinstitutionalization continues and residents from Pearson and other long term care settings will continue to move into the community.
- Increasing survival rates of younger adults with moderate to severe physical disabilities (Gnaedinger, 2001).
- Increasing numbers of younger adults with moderate to severe chronic illnesses and disabilities (Gnaedinger, 2001).
- Increasing numbers of individuals with disabilities who choose to live in their own community homes and need considerable supports to do so will place greater pressure on community-based services, and there will be growing demands for services as these people age. (Gnaedinger, 2001).

ROLES OF HOUSING AND SUPPORT AGENCIES

Individuals with physical disabilities may obtain supports and funding from a range of sources, including the Ministry for Children and Families, the Ministry of Health, Workers' Compensation Board, Insurance Corporation of B.C., Canada Pension Plan, B.C. Benefits, regional health authorities, housing agencies and non-profit housing societies or co-operatives. Most individuals with significant physical disabilities who require supports do not have independent incomes and use the services provided through the regional health boards to obtain supports.

Role of Vancouver/Richmond Health Board

The Vancouver/Richmond Health Board is responsible for a range of supports for people with physical disabilities, including home support and home care nursing; the Choices in Supports for Independent Living (CSIL) program (which includes the Consumer Support Group (CSG) program); other individualized health support funding contracts; and all publicly funded long term care and residential care facilities.

The Vancouver/Richmond Health Board (V/RHB) has endorsed housing as a determinant of health, and has also adopted the recent *Strategic Plan for Housing Services.* That document noted that "The V/RHB has been strongly supportive of the belief that housing is both a fundamental right and a critical determinant of a person's health... The V/RHB wishes to take an active role in housing and recognizes the need for a clearly articulated plan to guide the planning, development, funding and evaluation of housing services appropriate for health authority involvement." (page 6).

While the Vancouver/Richmond Health Board plays a key role in the provision of housing and supports for people with physical disabilities, this constitutes only a small component of the Board's overall responsibilities. The Health Board is required to address a range of health issues and has a responsibility to work toward equitable access to health resources and services for all groups, although services and programs must be balanced with the financial capacity of the health system. While financial capacity may not exist to immediately implement a plan, the planning process can provide a guide for planning future financial allocations and priorities in relation to housing and support goals.

Role of BC Housing

BC Housing, the provincial agency responsible for housing, was established in 1967. When the federal government was involved, an average of 1,500 to 1,800 units of affordable housing, including 5% wheelchair accessible units were built each year in British Columbia.

The provision and funding of social housing has historically been a federal responsibility. The federal government withdrew completely from this role by 1994 and since then, only two provinces, Quebec and British Columbia, have maintained social housing programs.

Since the federal government withdrew from the development of housing in the early 1990's (they continue to subsidize some existing housing projects), the provincial government has increased its role, and has provided over 7,100 units since the federal government withdrew (including 5% wheelchair accessible housing in most projects).

The role of BC Housing includes the development, funding and management of affordable housing. BC Housing has an annual budget of $208 million, and administers subsidies for approximately 50,000 units of housing. The subsidized housing includes 8,000 units of housing directly managed by BC Housing, 26,000 units of housing owned and operated by non-profit societies and co-ops, and rent supplements (including SAFER – Shelter Aid for Elderly Renters) to more than 12,000 households in the private rental market.

In terms of wheelchair accessible housing, BC Housing has two potential roles: the development of units and, if requested, assisting non-profit and co-op housing providers in filling vacancies with tenants in need of wheelchair accessible units.

Tenant selection procedures are the responsibility of the non-profit or co-op housing operator and operating agreements with the housing providers include tenant selection procedures that are "documented and defensible... non-discriminatory and meets the legal requirements of human rights legislation and the Residential Tenancy Act."

BC Housing has a very limited role in filling vacancies in non-profit or co-op units, including wheelchair accessible units. The goal of BC Housing is to act as a resource to the housing providers, assisting them by providing potential tenants from the housing registry if the housing providers need assistance in filling vacancies. Many housing providers manage their own applicant lists and do not access the BC Housing registry.

Until recently, BC Housing referred applicants directly to 25% of the units in any BC Housing subsidized development. In April 1999, that responsibility was devolved to non-profit and co-op housing providers at their request. At this time, BC Housing is responsible only for vacancies in its directly managed units. All other vacancies are filled directly by the co-ops or the non-profit societies that manage the housing; these organizations may contact BC Housing for referrals from the BC Housing applicant registry if they wish. Additionally, BC Housing accepts applications on behalf of some housing providers.

In the Lower Mainland, BC Housing is developing a web-based housing registry in partnership with the B.C. Non-Profit Housing Association and the Co-operative Housing Federation of B.C. The objective of the housing registry to provide a single application point for those seeking housing instead of having to apply to each individual housing provider. Housing providers will be able to access the registry using the Internet and do not need to maintain their own applicant registry. An additional goal of the housing registry is to provide an effective tool for networking with community agencies who have clients in need of housing.

Wheelchair Accessible Housing in the Lower Mainland

In the Lower Mainland, most of the housing that is wheelchair accessible is in the social housing sector. There are several different housing programs within this sector:

Federal co-ops: In B.C. there are about 250 federal co-ops, most of which are in the Lower Mainland. The developments were funded by the federal government through Canada Mortgage and Housing Corporation. These are also known as Section 56-1 co-ops. Each co-op operates independently and is managed by its members. BC Housing plays no role in the operation of co-ops that were developed through the federal funding programs of Canada Mortgage and Housing Corporation.

There are also about 50 Index Linked Mortgage (ILM) co-ops which have both federal and provincial involvement. BC Housing provides the housing subsidy, but the Operating Agreement is with CMHC.

The Co-operative Housing Federation of British Columbia is the umbrella resource organization for housing co-operatives.

Provincial co-ops: There have been 10 to 12 co-ops developed and funded through BC Housing. The umbrella resource organization is the Co-operative Housing Federation of British Columbia.

Provincial non-profit housing: Over 100 non-profit housing providers in the Lower Mainland own and operate one or more buildings that are subsidized with funding from BC Housing. The umbrella resource organization is the B.C. Non-Profit Housing Association.

BC Housing: BC Housing directly owns and operates 8,000 units of social housing. In the Lower Mainland, BC Housing directly manages 14 developments which have wheelchair accessible units.

CURRENT HOUSING BARRIERS AND SOLUTIONS

Stakeholder consultation identified numerous barriers and potential solutions related to the provision of housing; including:

- Design and construction of wheelchair "adaptable" units.
- Design and construction of wheelchair "accessible" units.
- Lack of links between those in need of housing and those providing housing.
- When units become available, a subsidy may not be available.
- Location of wheelchair accessible housing.

Interviews with stakeholders identified current barriers to housing for people with physical disabilities. There is a general perception of a lack of wheelchair accessible housing. There are several aspects that impact this perception, including number of units, location of units, design of units, utilization of units, and access to information about availability of units.

Throughout British Columbia there are a total of more than 1,142 wheelchair accessible social housing units in co-ops, non-profit housing and BC Housing directly managed housing; over 1,000 of these units are in Vancouver and Richmond.

The current BC Housing applicant registry currently has 115 applicants for wheelchair accessible housing; of those 60 are in the Lower Mainland. (By comparison, there are 10,000 families on the applicant registry.) Applicants requiring wheelchair accessible housing comprise 1% of all applicants, and 5% of all units constructed are wheelchair accessible.

The 5% accessible units policy has been consistently applied since 1985. In recent years there have been several housing providers in the Lower Mainland that have made provision above this level, including St. George's Place (all 19 units accessible or adaptable), Millennium Place (all 39 units accessible or adaptable), and False Creek Steveston (10 accessible units out of 20). These developments were initiated by housing providers with a mandate to provide wheelchair accessible housing.

Barrier: Design and Construction of Wheelchair "Adaptable" Units

BC Housing capital funding and design and construction guidelines define and differentiate "wheelchair accessible" and "wheelchair adaptable" units. Units may be constructed as either "adaptable" or "accessible". The design and construction guidelines for "accessible" units are much more comprehensive than for "adaptable" units.

For "accessible" units, the capital funding is increased by 12% to provide for the higher construction costs related to the size of the unit and the fittings and fixtures required. For "adaptable" units the increased funding is 6% as fewer specialized provisions are required.

The funding formula of 6% additional funding for "adaptable" units, or 12% for "accessible" units (which have more stringent design guidelines), can impact on the type of units housing providers select on the basis of capital budget impact.

The primary barrier with "adaptable" units is that there is no funding mechanism for future adaptation of "adaptable" units when required, leaving them unsuitable for tenants with physical disabilities who require the adaptations.

While these units may be suitable for some individuals with various disabilities or for individuals who do not have a disability, they are not suitable for individuals who use wheelchairs and require accessibility in order to be able to live in the unit.

BC Housing has funds available for modernization and improvements, which could potentially be allocated to adaptation of units. However, this funding is limited and is often used for capital projects in existing buildings, such as repairing leaks, re-piping plumbing, replacing elevators and other large capital repairs.

Solutions:

For individuals with physical disabilities who require fully accessible units, "adaptable" units do not provide appropriate housing. This is particularly an issue in the Lower Mainland because many individuals with disabilities choose to live in the Lower Mainland where there are community resources and amenities.

It is recommended that BC Housing consider the role and value of "adaptable" units in their MUP calculations and design and construction guidelines, particularly given the limited funding mechanisms to implement adaptation.

From the perspective of potential tenants with physical disabilities, replacing "adaptable" units with "accessible" units would contribute to the provision of more appropriate housing.

Barrier	Solutions	Partners
Design and construction of wheelchair "adaptable" units	• Review of role and value of "adaptable" units compared with "accessible" units.	BC Housing
	• If "adaptable" units are retained, provide funding mechanism for adaptation when required.	BC Housing

Barrier: Design and Construction of Wheelchair Accessible Units

Many consumers have identified the design and construction of wheelchair accessible units as a barrier. The BC Housing HOMES BC design guidelines include wheelchair accessible housing units; however, these are guidelines only and in some cases the units do not fully meet the guidelines, usually due to spatial and budgetary constraints at the design stage. There is considerable variability in the size, design features, and accessibility of newly constructed wheelchair accessible housing units. In part, this may be because the provision of all requested design features increases the unit size and cost, thereby increasing the cost beyond the additional 12% capital allocation.

It may also be partly due to lack of design expertise in relation to the functional requirements for accessibility. The housing provider is responsible for selecting the architect and ensuring that the design meets their goals, including the wheelchair accessible units.

The HOMES BC design guidelines are comprehensive, but BC Housing does not generally utilize them as compliance mechanisms. It is recognized that many elements of the design will depend on other capital development conditions, including building configuration, budget and the housing provider's priorities and goals. The BC Housing technical staff evaluate the design of wheelchair accessible units and provide feedback to the housing sponsor group. The current trend for BC Housing is a shift away from the micromanagement of the design. The role of BC Housing in this area is as a resource to the design and development team and the housing provider.

Many design elements that are not addressed in the design guidelines can also compromise accessibility. For example poor circulation spaces within the unit may comply with guidelines but are not well designed. For individuals with significant physical disabilities, access to common areas may require electronic controls to unlock and open doors or use elevators. Neighbourhood location may also be viewed by individuals with disabilities as unsafe or inappropriate if it is not located near to accessible transit and amenities.

As with the adaptable units, if an accessible unit is not appropriate, there is limited funding for renovation or adaptation to meet the functional requirements of a potential tenant.

The design guidelines pertaining to accessibility are subject to ongoing revision. There may be a need to revise the design guidelines to meet the needs of the growing population with significant physical disabilities.

Most of the design standards and guidelines are based on the functional capacities of a paraplegic with good strength, balance and range of motion. Of the units provided, the design may be inappropriate for many individuals who use wheelchairs. Design of accessible housing can also be done on a project specific basis; such developments may provide accessible units that exceed BC Housing design guidelines.

Research (Taylor, 1996) on consumer satisfaction with wheelchair accessible housing noted that the consumer profile of occupants of wheelchair accessible social housing was likely changing, and that occupants would have different, and greater needs than historically. It was noted that the majority of study participants used electric, not manual wheelchairs, and that trends such as deinstitutionalization and population aging, would also impact the consumer profile of occupants, resulting in increasing numbers of individuals with significant physical disabilities.

The design guidelines should address the growing demand for electronic controls such as automatic door openers, infrared controls for elevators, proximity readers for secure common doors, ceiling track lift systems, and other technologies which facilitate independence and accessibility. All of these design features require design and construction guidelines and should be considered in terms of capital budget implications.

Wheelchair accessible units in current housing stock vary widely in age and have been constructed under a number of different housing programs. The majority were built under the Canada Mortgage and Housing Corporation federal housing program.

The result of all of these factors is that many "accessible" units are not appropriate for people with significant physical disabilities.

Solutions:

There is a need, particularly in the Lower Mainland, to recognize that potential tenants needing wheelchair accessible housing are increasingly likely to have significant physical disabilities. Current BC Housing design guidelines may not fully meet their accessibility requirements.

BC Housing should ensure that the wheelchair accessible guidelines are appropriate for those who are currently seeking accessible housing. Changes to the guidelines should be based on a clear functional rationale and on the needs of the current population in need of accessible housing. There may be a need to recognize variations in the level of accessibility required, particularly in the Lower Mainland compared with other areas of the province, where people with significant physical disabilities are less likely to live.

Compliance with the guidelines should be monitored to ensure that the units will be functional for the intended clients. An inappropriately designed unit will not meet the needs of the intended tenant population, nor will it be a desirable unit for individuals who do not have disabilities.

BC Housing should consider education initiatives for staff who are responsible for reviewing and evaluating plans of wheelchair accessible units, to enhance their awareness and understanding of the design and functional issues in relation to accommodating individuals who use wheelchairs.

Disability advocates should consider the value of providing education and awareness opportunities for BC Housing staff, for designers and architects, for housing providers, for resource groups, and for other interested parties involved in the provision of affordable, accessible housing.

There is a need to ensure that there is consensus in determining "appropriate" design solutions. This requires a functional understanding of disability, and expertise in both design and physical function. Occupational therapists and some programming and design professionals may have appropriate skills to evaluate designs; some individuals with disabilities may also be able to contribute expertise, although it is important to recognize that each individual's needs vary and consumers may be experts only on their own unique abilities and functional requirements.

BC Housing should consider evaluating the adequacy of the 12% allocation for the provision of accessible features within units.

BC Housing should consider a mechanism for the renovation or adaptation of units that are designated as "accessible" but which are not functional. These units should either be upgraded to provide appropriate accessibility, or removed from the stock of units designated as accessible and used to accommodate individuals who do not have a disability and use a wheelchair. This initiative should include consumers, housing providers, and potential funding partners, such as B.C. Rehabilitation Foundation, B.C. Real Estate Foundation, and Canada Mortgage and Housing Corporation.

Barrier	Solutions	Partners
Design and construction of wheelchair "accessible" units	• Design guidelines should be reviewed to ensure that they meet current functional needs.	BC Housing
	• Training and education re. design of wheelchair accessible units.	BC Housing housing providers architects and builders Disability organizations
	• Continue with ongoing design review to ensure compliance with guidelines.	BC Housing
	• Review of 12% capital allocation.	BC Housing
	• Mechanism for renovation and adaptation of units that are designated accessible but which are not functional.	BC Housing in partnership with consumers, housing providers and funding agencies.

Barrier: Lack of links between those in need of housing and those providing housing.

There are significant barriers on both sides in linking those in need of housing to those who provide housing. Housing providers consistently report difficulty in identifying tenants with disabilities to occupy their wheelchair accessible units, and conversely people with disabilities report difficulties in identifying and securing housing.

One barrier is that the application system for housing is not centralized. Accessible subsidized housing is offered through a range of programs and organizations, and applicants may need to register with each prospective housing provider or housing site, as housing providers select their own tenants. BC Housing manages an applicant registry and this registry is used by BC Housing to fill its directly managed units. This registry can also be accessed by housing providers if they choose.

For housing providers, there is no centralized system or resource for identifying potential tenants with disabilities. This has been identified as a gap that housing providers would like disability advocates and organizations to address in order to meet their own goals. Conversely, disability advocates and organizations have argued that housing providers, such as BC Housing, should have a formal role in actively matching tenants. This potential solution is not compatible with housing policies and practices. Federally funded co-ops, for example, have no association with BC Housing, and housing societies are actively working to have greater autonomy and control in tenant selection.

Another barrier that has been identified by consumers is that the intended use of these units as specifically to accommodate individuals who use wheelchairs is not well understood, and that "disability" can be interpreted to mean an individual who may have some disability, but does not use a wheelchair, such as an individual with arthritis or autism.

A Vancouver survey of the units (Sangha, 1984) found that while 89% of the occupants had some form of disability, only 64% used a wheelchair. 9.1% of the occupants had no disability, and 2.3% of the units were vacant.

Anecdotal evidence from consumers and advocates has also illustrated concerns regarding discrimination. It has been reported that in some cases there may be an unwillingness to accommodate people with disabilities who are perceived to have "nothing to contribute", for example to the operation of a co-op. Discriminatory attitudes and lack of awareness reportedly remain a barrier.

Conversely, housing providers have expressed difficulties in identifying potential applicants when they have had wheelchair accessible units vacant. Many housing providers report having tried unsuccessfully to locate individuals in need of wheelchair accessible units. In some cases, it may be difficult to fill a unit because the design of the unit does not meet the potential tenant's accessibility requirements, or because the location of the unit may be unsuitable, as previously discussed. A study of wheelchair accessible housing in Vancouver (Sangha, 1984) found that 77% of housing sponsors indicated they had experienced difficulty finding a wheelchair user to occupy a modified unit. 58% said they couldn't find a person who used a wheelchair; 17% said the unit was the wrong size for the applicant; 17% said the development location was perceived as too isolated by the applicant; 13% said the applicant had problems with the unit design; 9% said neighbourhood amenities were lacking or inaccessible, and 6% noted problems with features of the building other than the unit interiors.

BC Housing often receives calls from housing providers who have wheelchair accessible units who are seeking assistance in filling a vacancy. BC Housing is able to search their applicant registry and provide applicant names and also shares the vacancy information with all staff.

The message from housing providers is that they are unable to find anybody in need of their accessible units, and the message from disability organizations is that they are unable to find any housing. Evidence indicates that both are valid issues.

Solutions:

There is no simple solution that BC Housing can implement. BC Housing is not involved in selecting tenants for any units except those that it manages directly. BC Housing does not monitor the allocation of wheelchair accessible units; the expectations regarding use and allocation are documented in the Operating Agreement between BC Housing and each housing provider. BC Housing is a resource to housing providers and is not in a regulatory enforcement role.

There is a need for education, awareness and the building of connections between those organizations that provide housing and those organizations that assist individuals with physical disabilities to secure housing. As an example, BC Housing engaged in an initiative with women's transition houses which were constantly facing the challenge of trying to secure housing for women in need of permanent, affordable housing. By facilitating connections between the housing providers and the women's transition house organizations, awareness and relationships were established, and at this time, women leaving transition houses are now more readily accessing housing.

There is a need for disability organizations to engage in the same type of partnership building with BC Housing and housing providers to establish connections and relationships that will facilitate access to housing when clients need it.

This relationship building should also include awareness and education around the intended and appropriate use of these units and the range of tenants who might move in. This would be a proactive and effective approach to addressing the perceived discriminatory attitudes that have been reported. Of equal importance, there is need for education about the type and level of disabilities that need to be accommodated, particularly the greater need to accommodate individuals with significant physical disabilities in the Lower Mainland.

There are specific organizations and events which offer valuable opportunities for networking and education. Organizations include BC Housing, the B.C. Non-Profit Housing Association, and the Co-operative Housing Federation of B.C. Both the BCNPHA and the CHF-BC have regular newsletters and annual conferences, as well as other workshops and sessions.

BC Housing is developing an online housing registry and this tool may contribute to more ready awareness of the availability of accessible units. As the online registry becomes more widely used by housing providers, it will be easier for applicants to obtain information about the number and location of wheelchair accessible units that are available.

BC Housing and disability advocates and organizations need to continue to work together so that when staff at BC Housing receive calls from housing providers who have wheelchair accessible units available, the staff at BC Housing are able to connect the appropriate parties, are able to forward the information to appropriate resources within the disability community, and are able to provide the housing provider with useful information.

Barrier	Solutions	Partners
Lack of links between those in need of housing and those providing housing	• Awareness and education initiatives directed to housing providers. • Partnership building between disability consumers, advocates and organizations and housing providers and housing organizations. • Awareness, access and utilization of online housing registry.	Consumers, advocates and disability organizations with support from BC Housing, and directed toward BCNPHA, CHF-BC, and housing providers. Access and utilization by disability consumers, advocates and organizations assisting individuals to find housing.

Barrier: When units become available, a subsidy may not be available.

Another issue that can be a barrier is the availability of rent subsidy to ensure that the unit is not only accessible but also affordable. This is primarily an issue with federally funded co-ops, which have a fixed subsidy pool.

The great majority of those seeking wheelchair accessible social housing will require a full subsidy. If a wheelchair unit becomes available but is not subsidized, the unit is usually inaccessible for financial reasons.

Federal co-ops, which are not funded by BC Housing, have a fixed subsidy pool. If the subsidy pool has been fully allocated, and a wheelchair accessible unit becomes available, there will not be a subsidy available for it or it may be a limited subsidy. Conversely, in some cases, when a wheelchair accessible unit has become available, the subsidy that had been allocated to that unit is re-allocated to another member in need of a subsidy. In either case, the unit is not affordable to most individuals with physical disabilities without a subsidy.

In BC Housing HOMES BC developments that have market units, there is greater flexibility in the allocation of subsidies. If a subsidy is required for a potential tenant of a wheelchair accessible unit, then an increase in the operating budget may be negotiated. (All other co-ops and non-profit housing is fully subsidized and this is not an issue.)

Regardless of the housing program, wheelchair accessible units which are not subsidized are not affordable (and are therefore not accessible) for most individuals with physical disabilities and the lack of subsidy is a significant barrier.

Solutions:

For federal co-ops, assigning a subsidy that is tied to each wheelchair accessible unit, should be considered as a long term goal. Although this deviates from the standard subsidy models, the demographic data on disability and income justify this approach.

In order to better assure the availability of subsidies for wheelchair accessible units, disability advocates and organizations need to undertake to build awareness and education of the issue and to ensure that housing providers and organizations representing housing providers understand the importance of subsidies for wheelchair accessible units, based on the demographic data.

Organizations such as CMHC, BC Housing, the BCNPHA, and the CHF-BC should co-operate with disability organizations and work with housing providers to ensure better provision of subsidy funds for wheelchair accessible units.

Barrier	Solutions	Partners
When units become available, a subsidy may not be available	• Exploration of changes to subsidy allocation models. • Education and awareness to promote subsidy availability.	Consumers, advocates and disability organizations with support from BC Housing, and directed toward CMHC, BCNPHA, CHF-BC, and housing providers.

Barrier: Location of wheelchair accessible housing.

BC Housing, and before it, CMHC, have mandated that in general, 5% of the units in any project are to be wheelchair accessible. As a result, wheelchair accessible housing is provided in the all of the locations in which social housing is provided. However, in many cases, these locations may not be appropriate.

Units may be considered to be inappropriately located if the neighbourhood is unsafe, if there is a lack of access to accessible transit or to amenities, or if the surrounding neighbourhood has unsuitable geography, such as steep hills. Many people with physical disabilities feel vulnerable and personal safety is a particularly important consideration.

The allocation of wheelchair accessible units is based on each development and unit allocations cannot be transferred from one development to another development because each development is undertaken by different housing providers. If there is no demand in the community, or a location is unsuitable for wheelchairs, the housing provider may choose to make the case that the development should not include the 5% accessible units. However, there is no means of re-allocating the potential units to another, more appropriate site, other than through negotiations with different housing providers. BC Housing has general proposal submission guidelines and is not in a role of determining the allocation of wheelchair accessible units based on site criteria.

Housing providers are responsible for site selection and submission of their housing development plans to BC Housing. BC Housing provides funding allocations to housing providers who have identified the specific and unique needs for affordable housing in their communities. This need may or may not include wheelchair accessible units, and in some cases, it may include significantly more than 5% of units, (such as at Noble House, St. George's Place, Millennium Place and False Creek Steveston).

Solutions:

Disability organizations should work with housing providers, resource consultant groups, and BC Housing to encourage them to consider the suitability of each site for wheelchair accessibility and to provide more than 5% of all units on sites which offer appropriate locations, particularly in the Lower Mainland.

Barrier	Solutions	Partners
Location of wheelchair accessible housing	• Educate housing providers and resource groups to consider location as a criterion in the provision of wheelchair accessible units within each project.	Disability organizations, working with housing providers, resource groups and BC Housing.

CURRENT SUPPORT BARRIERS AND SOLUTIONS

Stakeholder consultation identified four barriers related to support issues.

- The first and single most significant barrier identified was inadequate support funding to enable people with disabilities to enjoy the housing, support and quality of life that they would prefer. This was noted as a particular barrier for individuals who require access to 24 hour support and individuals who are currently living in care facilities.
- A second barrier identified by stakeholders was health care system policies and practices, including a lack of collaboration and continuity.
- A third barrier is the need to provide for transitions for individuals re-entering the community or moving into a new model of housing and supports.

Barrier: Inadequate support funding.

Due to budget constraints, current funding for individuals who require significant supports combine the provision of housing and supports and are based on some form of shared care. The principles and values of individual autonomy, flexibility, choice, and ability to live as a fully participating citizen within the community are compromised by limited funding of supports. The provision of supports was characterized as meeting only basic needs. It was noted that supports are often not adequate to allow community participation, and that if a person is isolated in their own home, they might as well be in a care facility, as they remain unable to participate in the community. With supports restricted to the provision of basic health and personal care, many individuals with physical disabilities who require significant support are unable to achieve the goals articulated in the values and principles.

Funding for supports was identified as inadequate in all areas, including:

- home support
- home care nursing
- provision of attendant care hours for CSIL and shared care programs
- lack of nursing services for people who are medically fragile
- physical rehabilitation services
- vocational rehabilitation services
- psychosocial support
- recreation therapy
- co-ordination between agencies and organization providing the above resources

There was concern with overall changes in health care: government cutbacks in all areas of service; trend toward the provision of fewer services; loss of options and fewer choices, including fewer contract service providers; and system changes that would reduce flexibility.

The recent cutbacks throughout the health care system have impacted on the provision of supports in the community. Combined with an aging population that is increasing demands on limited health care resources, there are growing concerns and fears that the provision of supports to individuals with physical disabilities is being, and will continue to be, reduced and diminished, instead of enhanced to meet consumers' goals and preferences.

Specific fears around trends and practices included:

- reductions in home support to people with disabilities
- loss of flexibility as services are reduced
- inability to obtain sufficient hours of care to meet needs
- reductions to support hours already allocated
- pressure to use a shared care model
- sense of competition with seniors for limited available resources - it was reported that some case managers have told clients that "you're taking away from others".
- expectation that people can be alone at night
- forcing shared care on people who live in the same building
- financial efficiency becoming the default, reducing choice
- trend toward fewer services
- fear of loss of choice and options with fewer service providers
- resistance to understanding the value and financial sense of individualized funding
- too much emphasis on meeting only basic care needs and failing to meet needs for life within the community – gaining education and employment
- with shared care programs, can become an care facility located in the community because the supports are tied to the building and individuals cannot obtain supports to go out

Solutions:

In general, the solution was perceived to be "more funding". Specific suggestions included a designated funding envelope for individuals with physical disabilities; this would serve to defuse the perception that resources are being "taken away from" seniors or other populations in need.

Individualized funding and the linking of supports to individuals instead of housing was also advocated by several stakeholders as a solution. This contrasts with the range of housing and support models, many of which are based on integration of the housing and supports as key to the operational model. Intrinsic to individualized funding is the notion that each individual should not be required to share care or housing, regardless of the level of support required, and that funding should be provided for all levels of support, including funding for 24 hour individualized supports if needed. However, given the reality of health care funding, it is only possible to implement this model on a limited basis. At present, individualized funding is available up to a maximum, which is less than 24 hours a day.

It was also advocated that existing care facility funding be allocated to individuals and that they be allowed to take this funding with them and move out of the care facility. This concept is based on the precedent established with the closures of Woodlands and Riverview Hospital and the transfer of those funds into the community. That, and other models pioneered by the developmental disabilities movement have been cited as examples that could be transferred to individuals with physical disabilities.

Many of the barriers and fears identified are valid. Health care funding is limited and there are significant demands and pressures on the system at this time. In principle, the provision of resources to individuals with physical disabilities must be equitable with the provision of supports to other populations, including seniors, individuals receiving home support and individuals currently living in the community with a physical disability.

The solution at this time is to identify innovative approaches, incremental improvements and specific strategies that are consistent with the values and principles articulated in this report, and balance the goals of quality of life for individuals with disabilities living in the community with the financial limitations and equities within the health care system.

Strategies should emphasize flexibility and choice in the provision of both housing and supports.

Key to achieving this solution is the involvement of consumers themselves – those who will be using the housing and supports. Consistent with the values and principles articulated, "Nothing about me without me" should be the goal, providing consumers with a role and the opportunity to participate in the development and provision of housing and supports.

Barrier	Solutions	Partners
Inadequate support funding	• Consider increased individualized funding.	Vancouver/Richmond Health Board
	• Consider strategies to enhance flexibility and choice within funding limitations.	Vancouver/Richmond Health Board
	• Consider a designated funding envelope for housing/support models for persons with physical disabilities.	Vancouver/Richmond Health Board

Barrier: Health care system policies and practices.

Many of the stakeholders identified systemic issues related to policies and practices in the provision of supports: descriptive terms included "rigid", "resistance to change", "bureaucracy", "paternalism", "inhibition of creativity", "lack of knowledge", and lack of respect for, and inclusion of, people with disabilities themselves.

Overall, stakeholders identified systemic weakness at the policy level. There is a lack of awareness, understanding and respect for consumers' goals and expectations. There is a lack of enabling mechanisms or policies that would facilitate more progressive, inclusive or flexible policies and practices. Programs are designed rigidly and are planned for a geriatric population; they are not appropriate for people with disabilities, and there is no flexibility to adapt programs.

Another significant issue at the policy level is the lack of communication, co-ordination and co-operation between different Ministries and agencies. There are no formal mechanisms to facilitate the arrangements that are frequently required for specific cases and this is an ongoing irritant at the practice level. Improved communication, co-operation and collaboration is required, specifically between the Ministry of Health, regional health authorities, Ministry for Children and Families, Ministry for Social Development and Economic Security, and BC Housing.

The values and principles articulated in this report include "system collaboration and continuity". There is a need for continuity and linkages to allow people with disabilities to move between health regions, between organizations and agencies, and to benefit from the co-operation of various government ministries and programs.

This barrier is manifested at many levels and with many outcomes, but for many individuals as well as agencies and organizations, the lack of collaboration constitutes an insurmountable barrier.

Issues include the challenges of trying to move into housing from a care facility setting, including the need to secure funding for supports, equipment and housing, secure housing, secure equipment, arrange supports, and secure housing. Securing all resources in a timely manner can be very difficult.

Funding issues can involve disputes between health regions, or between Ministries. It can also involve protracted negotiations with funding authorities in order to secure adequate funding or develop a viable model of supports.

At both the policy and practice levels, there is no clear access point and process for people who wish to secure housing or supports. There needs to be more clear information available to individuals with disabilities to assist them in learning about options and making informed decisions and choices.

At the practice level, several specific barriers were identified, including:

- The need to match the provision and allocation of resources with appropriate accountability mechanisms, to ensure transparency and equitability for consumers. It was noted that at this time, there is no independent mechanism for appealing or challenging decisions pertaining to support allocations to individuals. Without accountability, there is a power imbalance and clients have no control. This system precludes consumers and professionals working collaboratively or on a basis of trust.

- Professionals in a "gatekeeper" role, and the perceived arbitrary decision making power in determining the provision of supports. Discriminatory attitudes that people with disabilities require too many resources and are taking away from others in need, such as the elderly, were specifically cited as a concern.

- The need to recognize and respect that that an individual with a physical disability has the right to make his or her own lifestyle choices, and to choose how to live in his or her own home. It was noted that conflict may be inevitable when other people (service providers) are involved in an individual's life. Issues may arise in relation to practices, liability, values, and control. There is a need to formally recognize and respect the right of the clients to exercise control over their own lives.

- Overall, there was a perception that the knowledge and will to create better housing and support options was lacking. There is a lack of information and resources to enable effective consumer involvement. For example, there are specific recurring issues that are unresolved, such as the sequence and timing of acquiring housing and acquiring supports and equipment; different bureaucratic barriers require one before the other, resulting in deadlocks and missed opportunities.

Solutions:

The solutions to this barrier exist at several levels. There is a need for structural and policy changes within Ministries and agencies that have a role in service delivery. There are no simple or systemic solutions; barriers have tended to be resolved on a case specific basis, and few formal linkages have been established. Incremental steps to establish linkages between all levels and parties is needed. There is a need for formal strategies to build linkages among all levels of organizations and between different organizations. Development of committees or working groups may be one effective strategy. There is a role for advocacy and consumer organizations to continue to demand better system continuity and to promote collaboration.

There is a need for changes to programs and practices that impact on people with disabilities. And there is a need for consumers and advocates to be involved in defining and reaching solutions. For consumers and advocates to be involved effectively, there is a need for more empowerment, and more information and advocacy resources.

There is a need to develop a clear and comprehensive framework for housing and supports for people with physical disabilities, and to develop the resources to assist individuals to learn about options and make informed decisions.

Barrier	Solutions	Partners
Health care system policies and practices	• Consumer involvement in the development of new options and choices.	Disability consumers, advocates and organizations working with V/RHB
	• Empowering and enabling policies appropriate to the needs and goals of people with disabilities.	Vancouver/Richmond Health Board
	• Greater flexibility and more receptivity to innovation.	Vancouver/Richmond Health Board
	• Improved co-operation and collaboration between Ministries and agencies. Formal strategies to develop better linkages and continuity, such as committees and working groups.	The Ministry of Health, V/RHB, Ministry for Children and Families, Ministry for Social Development and Economic Security, and BC Housing, advocacy and consumer organizations. .
	• Improved communication of information and models of housing and supports.	V/RHB BC Housing

Barrier: Lack of transition opportunities.

"Transition" refers to the process of an individual developing, with assistance, skills and capacities; often with the goal that the individual will be empowered to gain greater control in identifying and accessing housing and support choices. The resources required to facilitate the transition process differ for each individual, depending on their personal circumstances; and for some, transition can be a lifelong process.

Transition is not a housing model or a support model, but is an array of specialized, time limited services and supports that meet the specific and unique needs of the individual who is changing or exploring either housing and/or support options.

In terms of housing and supports, there are barriers to facilitating transition.

Individuals who are entering the community with a disability, either following rehabilitation or long term care facility residence, often face great uncertainty in their goals, plans, abilities and the optimal housing and support solution that will meet their needs. Additionally, some individuals living in the community may wish to try a different model of housing and supports, but are unwilling to risk losing what they currently have.

There is a need for many individuals to have access to transition resources so that they may "try out" housing and support options and develop skills and experience as they make a transition back into the community or into a new housing and support model.

Barriers to this include both housing and supports: there are very limited formal opportunities for transition, and there is limited funding. A recent pilot project in Vancouver[3], has demonstrated the value of transitional programming. The evaluation of the pilot project recommends the continuation of the existing program and the expansion of resources to include a broader role in assisting people to achieve their community living goals and to develop their skills related to housing and supports.

Providing transition resources is integral to achieving the goal of being able to move people from rehabilitation back into the community without delay, and to assist individuals who wish to move out of care facilities. There is a Transition Implementation Committee at George Pearson Centre which is currently examining the issue of transition support. There are many approaches and solutions to providing transition resources; there is no single model which is appropriate to meeting the range of needs.

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[3] Community Integration Project, managed by the Victorian Order of Nurses and funded by B.C. Rehabilitation Foundation. The program operates two units of transitional housing at St. George's Place, a social housing project near to G.F. Strong and Vancouver General Hospital.

Solutions:

Transition can occur in any of the housing and support models identified, and there is the potential for some existing models to accommodate residents for that purpose. Transition needs to be recognized as a "best practice" which should be facilitated within existing models of housing and supports, and considered in the development of new housing and support resources.

Funding is required to provide the resources to manage and operate transitional supports, including assistance with negotiating for supports, assistance with securing permanent housing, assistance and "coaching" in the development of skills integral to community living, and ensuring continuity in the provisions of the range of rehabilitation, support and other services required based on individual client needs and goals.

The fear of individuals that they may not be able to "go home" to what they had if they wish to is legitimate. Policies and practices should ensure that individuals who wish to return to their previous setting have priority for any available vacancy.

Barrier	Solutions	Partners
Lack of transition opportunities	• Develop policy and procedures to allow for a "return" to previous setting from transition. • Incorporate the concept of transition into all planning for housing and support options. • Consider formalizing transition opportunities within currently available models of housing and support. • Consider transition needs in the development of new housing and support options. • Provide funding for transitional programming and resources.	V/RHB G.F. Strong, George Pearson Centre, other rehabilitation and long term care facilities, organizations which provide transitional supports, peer supports, advocacy, and skills development.

SUMMARY OF BARRIERS AND SOLUTIONS

Barriers	Solutions	Partners
Design and construction of wheelchair "adaptable" units	• Review of role and value of "adaptable" units compared with "accessible" units.	BC Housing
	• If "adaptable" units are retained, provide mechanism for adaptation when required.	BC Housing
Design and construction of wheelchair "accessible" units	• Design guidelines should be reviewed to ensure that they meet current functional needs.	BC Housing
	• Staff training and education re. design of wheelchair accessible units.	BC Housing housing providers architects and builders Disability organizations
	• Continue with ongoing design review to ensure compliance with guidelines.	BC Housing
	• Review of 12% capital allocation.	BC Housing
	• Mechanism for renovation and adaptation of units that are designated accessible but which are not functional.	BC Housing in partnership with consumers, housing providers and funding agencies.
Lack of links between those in need of housing and those providing housing	• Awareness and education initiatives directed to housing providers.	Consumers, advocates and disability organizations with support from BC Housing, and directed toward BCNPHA, CHF-BC, and housing providers.
	• Partnership building between disability consumers, advocates and organizations and housing providers and housing organizations.	
	• Awareness, access and utilization of online housing registry.	Access and utilization by disability consumers, advocates and organizations assisting individuals to find housing.
When units become available, a subsidy may not be available	• Exploration of changes to subsidy allocation models.	Consumers, advocates and disability organizations with support from BC Housing, and directed toward BCNPHA, CHF-BC, and housing providers.
	• Education and awareness to promote subsidy availability.	

Barriers	Solutions	Partners
Location of wheelchair accessible housing	• Educate housing providers and resource groups to consider location as a criterion in the provision of wheelchair accessible units within each project.	Disability organizations, working with housing providers, resource groups and BC Housing.
Inadequate support funding	• Consider increased individualized funding.	Vancouver/Richmond Health Board
	• Consider strategies to enhance flexibility and choice within funding limitations.	Vancouver/Richmond Health Board
	• Consider a designated funding envelope for housing/support models for persons with physical disabilities.	Vancouver/Richmond Health Board
Health care system policies and practices	• Consumer involvement in the development of new options and choices.	Disability consumers, advocates and organizations working with V/RHB
	• Empowering and enabling policies appropriate to the needs and goals of people with disabilities.	Vancouver/Richmond Health Board
	• Greater flexibility and more receptivity to innovation.	Vancouver/Richmond Health Board
	• Improved co-operation and collaboration between Ministries and agencies. Formal strategies to develop better linkages and continuity, such as committees and working groups.	The Ministry of Health, V/RHB, Ministry for Children and Families, Ministry for Social Development and Economic Security, and BC Housing, advocacy and consumer organizations.
	• Improved communication of information and models of housing and supports.	V/RHB BC Housing

Barriers	Solutions	Partners
Lack of transition opportunities	• Incorporate the concept of transition into all planning for housing and support options. • Consider formalizing transition opportunities within currently available models of housing and support. • Consider transition needs in the development of new housing and support options. • Provide funding for transitional programming and resources.	G.F. Strong, George Pearson Centre, other rehabilitation and long term care facilities, organizations which provide transitional supports, peer supports, advocacy, and skills development.

CURRENT MODELS OF HOUSING AND SUPPORT OPTIONS

The Advisory Committee and the consultant reviewed and evaluated a number of different models of housing and support (refer to Appendix D). In reviewing these, a range of housing options and best practices were identified and discussed. The following section provides an overview of a continuum of current housing and support options for individuals with physical disabilities who require access to both supports and affordable, accessible housing.

The continuum varies along two dimensions: the type of housing provided and the model of supports. This section describes five models of housing and four models of supports, and how they can be offered in different combinations to increase the range of consumer choice. The concept of transitional supports can be integrated into all of the housing and support options, based on specific and unique individual needs.

Five Models of Housing

1. Community Residence
2. Shared Home/Apartment
3. Clustered Dwellings with Shared Common Areas
4. Clustered Dwellings
5. Individual Dwellings

These models are described on the following pages.

Four Models of Supports

1. Staffed Housing
2. Shared Supports
3. Combined Staffed/Individualized Supports
4. Individualized Supports

These models are described on the following pages.

HOUSING MODELS

Housing Model 1 – Community Residence

Description:

- Housing is a shared living model. The scale ranges from about ten to sixty people.
- The building is usually self contained and purpose built. It may be located in the community, or it may be affiliated with a residential care setting.
- Each individual has their own bedroom or bedsitting room and washroom.
- Living, dining, activity and bathing areas are shared among all residents.

Examples: False Creek Residence, William Rudd House

Role Within A Framework of Housing and Support Options: This model is appropriate for many individuals with very significant physical disabilities who would otherwise be in a care facility due to a lack of viable housing and support alternatives that will meet their needs.

Advantages: This model is an option for individuals whose only other alternative is care in a long term care facility setting. The physical setting, scale and "feel" tends to be less institutional, and the provision of private space is more generous. It may offer some desirable amenities such as a therapeutic tub, which are less likely to be available in other community housing options. It may also be suitable for some individuals who experience isolation and loneliness in some other types of housing.

Disadvantages: Living is shared, and there is limited private housing space.

What is Required to Make It Work: An operator who has a commitment to providing both housing and supports in a shared living model, without the attributes of an institutional setting.

Housing Model 2 – Shared Home/Apartment

Description:

- Housing is a shared living model. The scale ranges from about five to eight people.
- The building may be a self-contained single family dwelling, or may be an apartment unit integrated within a larger housing project.
- Each individual has their own bedroom or bedsitting room and washroom.
- Living, dining, activity and bathing areas are shared among all residents.

Examples: Rotary House, Creekview.

Role Within A Framework of Housing and Support Options: Relative to the Community Residence Model, this housing type offers a more residential scale, with fewer residents living together. It also provides integration within a community housing environment.

Advantages: The smaller housing scale and the community integration are both advantages, relative to the Community Residence model. It may offer some desirable amenities such as a therapeutic tub, which are less likely to be available in other community housing options. It may also be suitable for some individuals who experience isolation and loneliness in some other types of housing. The provision of supports may be more cost effective than more individualized models.

Disadvantages: Living and supports are shared. There is limited private housing space.

What is Required to Make It Work: An operator who has a commitment to providing both housing and supports in a shared living model, without the attributes of an institutional setting.

Housing Model 3 – Clustered Dwellings with Shared Common Areas

Description:

- Housing is self-contained dwelling units, usually apartments. The scale ranges from about six to ten units clustered together.
- The dwelling units are integrated within a larger housing project and are co-located within the building.
- Each individual has their own fully self-contained apartment.
- Additional communal program support space is provided, such as dining, kitchen, social space, bathing and staff workspace.

Examples: Noble House, False Creek Residence at Steveston

Role Within A Framework of Housing and Support Options: This model offers each resident a private self-contained dwelling, combined with communal support spaces for shared living activities.

Advantages: Privacy and independence of living in a self-contained dwelling unit. Provision of communal amenities such as a therapeutic tub. Shared space for socializing.

Disadvantages: High capital costs relative to other housing models due to provision of both fully self contained units and communal amenity spaces.

What is Required to Make It Work: Adequate physical space to accommodate the design and adequate capital funding for both units and communal amenity spaces.

Housing Model 4 – Clustered Dwellings

Description:

- Housing is self-contained dwelling units, usually apartments. The scale ranges from about six to ten units clustered together.
- The dwelling units are integrated within a larger housing project and may be co-located in the building or may be scattered throughout the building.
- Each individual has their own fully self-contained apartment.
- There is no provision of communal program support space.

Examples: Bloomfield Gardens, City Club

Role Within A Framework of Housing and Support Options: This model offers each resident a private self-contained dwelling.

Advantages: Privacy and independence of living in a self-contained dwelling unit.

Disadvantages: Lack of communal amenities such as therapeutic bathing tub, or areas where individuals can socialize as a group.

What is Required to Make It Work: Adequate physical space to accommodate the design and adequate capital funding.

Housing Model 5 – Individual Dwellings

Description:

- Housing is self-contained dwelling units, usually apartments.
- Each individual has their own fully self-contained apartment.
- The housing type and configuration is not impacted by any model of supports.
- The dwelling units are integrated within a larger housing project and need not be co-located with any other units.
- The number of units will vary, but for social housing projects, it is generally about 5% of the total units.

Examples: St. George's Place, Millennium Place, and all other social housing with wheelchair accessible units.

Role Within A Framework of Housing and Support Options: Appropriate for individuals with disabilities who can live in housing that is not clustered in order to be compatible with the model of supports.

Advantages: Greater choice in the range of locations and units available.

Disadvantages: Barriers in terms of design adequacy, and identifying and securing units.

What is Required to Make It Work: Continued development of wheelchair accessible units within social housing projects. Better links between individuals in need of housing and housing providers – discussed further under "Barriers and Solutions".

SUPPORT MODELS

Support Model 1 – Staffed

Description:

- Staffing is based on a fixed model of 24 hour care that is linked and integrated with the provision of the housing component.
- Staffing may be within the housing, or on-site and on-call.
- Generally, staff are not able to leave the housing to accompany residents in the community.
- The staffing model may or may not be licensed, depending on the client profile and support requirements.
- Staffing is managed directly by the service provider.
- Residents have no direct, formal role in the provision of supports.

Examples: Rotary House, group homes, Blair Court, Kelly Court, False Creek Residence and FCR Steveston

Role Within A Framework of Housing and Support Options: If it is licensed, it is appropriate for individuals who are unable to direct their own care or who require assistance with decision making. Because it is typically for individuals with very significant disabilities, it may be appropriate for individuals with complex and/or deteriorating health conditions.

Advantages: This model is an option for individuals whose only other alternative is care in a long term care facility setting and who are unable to participate in support models that require the capacity to self-direct.

Disadvantages: The staffing model is not sufficient to provide support for residents' participation in community activities.

What is Required to Make It Work: An operator who has the capacity to provide both a housing model, possibly within the operating model of BC Housing, and to provide an appropriate and adequate model of supports that meets the needs of the tenants.

Support Model 2 – Shared Supports

Description:

- Tenants collectively manage their supports and care on a communal or shared basis.
- Tenants pool and share their supports as a condition of living in the housing.
- Tenants retain a third party representative with the role of supporting and facilitating the continuing process of negotiating shared supports, and managing staff or agency relationships on behalf of, and as directed by, the tenant group.
- Tenants, through their third party representative, may either hire staff directly or may contract with an agency.
- Tenants may, based on group consensus, change service providers, or change between direct staff or an agency.
- Tenants, with the support of their third party representative, are involved with and responsible for all aspects of the provision of supports, including recruiting, hiring, training, and managing staff, and planning and scheduling the provision of supports.
- Is not licensed, because tenants are able to "self-direct" and are responsible for staffing.

Examples: Creekview, Noble House

Role Within A Framework of Housing and Support Options: This model provides optimal client control and autonomy in negotiating and managing supports. Residents are directly responsible for the ongoing management of staff. The model is based on shared supports as an economically viable model of providing supports to individuals whose care needs exceed those that can be provided individually, generally because they require access to 24 hour support which is unavailable within current funding resources.

Advantages: This model is suitable for individuals who require a higher level of care than can be provided through CSIL, and who are able to direct their own care and can participate in the management of a shared model of supports.

Disadvantages: This model is not suitable for individuals who are unable to direct and manage their own care and to participate in the planning and management of the shared care with other tenants.

This model is not optimal for individuals who want the flexibility for supports that accompany them in the community and in their activities of daily life.

Requires a minimum number of people to attain a level of staffing appropriate to meet needs.

Staffing is generally limited to provision of supports on site as coverage is not sufficient to allow staff to accompany residents outside building.

What is Required to Make This Model Work: Tenants must be able to manage and direct their own care and to work with other tenants to negotiate a model of shared care. A third party organization is required to facilitate and support the group dynamics and the ongoing group negotiations and management of the shared care model. Tenants must be able to change staff or change support agencies if the provision of supports is not appropriate.

Support Model 3 – Combined Staffed/Individualized Supports

Description:

- Residents have access to limited staffing that is linked to the housing and provides a base level of support (typically overnight coverage), combined with individualized supports during other hours.
- Residents contribute some of their own support hours toward the provision of the base level of support.
- Residents have full control over their individualized supports, which will vary based on individual need.
- The communal supports are generally provided as a staffed model managed by the housing provider or support service agency.
- The combined supports may be provided as a "shared supports" model managed directly by tenants or may be provided as "staffed supports".
- Is not licensed because tenants are able to "self-direct".

Examples: Bloomfield Gardens

Role Within A Framework of Housing and Support Options: This model is appropriate for individuals who are able to and wish to direct and manage their own care and to live independently, but who require access to overnight support. Because CSIL provides a maximum amount of hours, for tenants who require overnight supports, it can be very difficult to develop a viable model of supports that allow the desired flexibility and support including overnight support. A model for housing that includes a base level of support such as overnight coverage creates the potential for greater flexibility and individualized supports in the utilization of the remaining CSIL funding.

Advantages: This model is suitable for tenants who can direct and manage their own care and want a high degree of independence and autonomy, including flexibility and the provision of supports for community activities. This model is also suitable for tenants who are on CSIL but are unable to obtain sufficient coverage to live independently. Tenants are able to select and manage their own staff or agency for some of their care.

Disadvantages: This model is less suitable for tenants who cannot direct or manage their own care unless they have a client support group. Tenants are not able to select or manage their own staff or agency for the shared care component.

What is Required To Make This Model Work: Tenants need to be on CSIL and to be willing and able to contribute a fixed allocation toward the basic supports that are integrated with the housing. A third party organization is required to manage the supports that are integrated with the housing.

Support Model 4 – Individualized Supports

Description:

- There is no linkage between the housing and the supports.
- The supports are linked to the individual, and may include CSIL, CSG, and various insurance settlements such as ICBC and WCB. May also include tenants who receive home support or home care nursing through an agency as arranged by their case manager, or who have private insurance arrangements.
- Is not licensed because it is an individual' s own home.

Examples: Choices in Supports for Independent Living (CSIL) clients, Consumer Support Group (CSG) clients, individualized contracts, home support and home care nursing clients, and private insurance clients.

Role Within A Framework of Housing and Support Options: This model is appropriate for the most independent of individuals with physical disabilities, who use no or limited supports, or who can manage to live independently with CSIL (or CSG).

Advantages: This model is suitable for individuals who want to live independently and who wish to manage and direct their own care, and are able to obtain sufficient supports independently. Does not restrict an individual's choice of housing type or location; support is fully portable.

Disadvantages: Tenants who require more support than can be provided to a single individual within current policies may not be able to utilize this model of supports.

What is Required To Make This Model Work: The funding available and the appropriate capacity for service provision (generally through CSIL or CSG) must be appropriate to meeting the individual's needs.

Integrating Housing and Support Models

The five housing models and the four models of supports can be combined to provide a range of housing and support options. Some combinations of housing and support models are not compatible because the housing type and the support model do not match in terms of the goals and provision of housing and supports.

The following table provides a summary comparison indicating how models may be combined to provide 11 different housing and support options.

HOUSING MODELS	SUPPORT MODELS
Community Residence	• Staffed Housing
Shared Home/ Apartment	• Staffed Housing • Shared Supports • Combined Staffed/Individualized Supports
Clustered Dwellings with Shared Common Areas	• Staffed Housing • Shared Supports • Combined Staffed/Individualized Supports
Clustered Dwellings	• Staffed Housing • Shared Supports • Combined Staffed/Individualized Supports
Individual Dwellings	• Individualized Supports

Housing and Support Models – Current Practices

The following table indicates how many individuals with physical disabilities currently live in these arrangements.

HOUSING MODELS	SUPPORT MODELS	NUMBER OF CLIENTS
Care Facility	• Staffed Housing	• 443 (Pearson and Long Term Care Facilities)
Community Residence	• Staffed Housing	• 24 (False Creek Residence)
Shared Home/ Apartment	• Staffed Housing	• 48 (Group Homes)
	• Shared Supports	• 6 (Creekview)
	• Combined Staffed/Individualized Supports	• None
Clustered Dwellings with Shared Common Areas	• Staffed Housing	• 10 (Steveston)
	• Shared Supports	• 7 (Noble House)
	• Combined Staffed/Individualized Supports	• None
Clustered Dwellings	• Staffed Housing	• 24 (Kelly Court and Blair Court)
	• Shared Supports	• None
	• Combined Staffed/Individualized Supports	• 6 (Bloomfield)
Individual Dwellings	• Individualized Supports	• 133

HOUSING AND SUPPORT OPTIONS – BEST PRACTICES

There is a need to continue to improve the current housing and support options and to create new models of housing and supports.

At this time, present housing and support resources for individuals with significant physical disabilities remain heavily weighted toward care facility options – at this time, 63% of individuals with significant physical disabilities who receive funding from Vancouver/Richmond Health Board are accommodated in long term care facilities or at George Pearson Centre.

Best practices can be identified by evaluating how existing models can be improved and by identifying new models of supports and housing.

The principles and values articulate a clear goal of maximizing independence and quality of life. To meet this goal within existing available resources requires a range of solutions to meet the range of individual disabilities, capabilities, preferences, and funding capacities.

Consistent with the values and principles, identification of housing and support needs must recognize the range of individual disabilities, lifestyles, goals and preferences, which relates to the goal of a range of consumer choices in both housing and support options. In recognizing and respecting the range of needs, best practices should include self-determination, choice, flexibility, equitability, diversity, and wellness.

Best Practice Policies

Self Determination

- The intrinsic right of individuals with physical disabilities to control their own lives to the best of their ability should be fundamental to the provision of housing and supports.
- The development of housing and support policies and practices should be based on recognition of, and respect for, the capacity and potential of people with disabilities. People with disabilities should be included in decision making processes and in identifying and evaluating policy and practice changes.
- Models of housing and models of support should support and facilitate self determination to the greatest extent feasible.

Choice

- Consumer choice and autonomy in both housing and supports should be facilitated and supported. The provision of individualized funding for both housing and supports should be recognized as the most effective mechanism for achieving this objective.

Flexibility

- Because of the relatively small population, any model of housing and supports should have the capacity to flexibly adapt to a changing client profile.
- Individual support and housing needs may change with time, due to changes in physical disabilities, or due to changing personal goals and priorities for housing and supports. It should be recognized and respected that individuals may wish to, or need to make changes in their housing and supports, including on a "transitional" basis.
- Housing and support models should be evaluated, based on client feedback, to ensure that the model is consistent with the values and principles and to identify and evaluate potential improvements to the model.

Equitability

- Access to the range of housing and support options should be equitable. Currently, there is less demand for some models (including some which have difficulty filling vacancies) while others are in very high demand and many who would like to access a model are unable to, due to lack of availability or inadequate support funds. The relative demand should be used to determine and prioritize the models for which additional capacity should be developed.
- There is a need to ensure that there is equitability in the provision of housing and supports, and in funding, for all individuals with physical disabilities. Equitability should be based on recognition of the diversity of individual needs, and the objective of equitable access to available resources within the health care system.

Diversity

- The range of disabilities and abilities is broad. Many individuals have physical disabilities that may be moderate to significant, but retain the cognitive capacity to fully manage their own lives. Other individuals have cognitive limitations that compromise their capacity to self-direct and may require measures to ensure consumer protection and accountability. The differences in individual abilities should be recognized and respected, with independence and autonomy optimized based on individual capacity.

- Individuals with disabilities may have stable conditions and good general health, or they may have degenerative or unstable physical disabilities and poor health. The model of housing and supports must be appropriate to these differences and recognize the diversity of physical conditions.

- It should be recognized and respected that a range of housing and support options are required to meet the diversity of physical disabilities.

Wellness

- The provision of housing and supports should be based on a broad understanding of health as more than meeting basic physical health and functional requirements. The goal should be to enable individuals to live as part of the community, to participate as citizens, and to experience the independence that housing potentially provides.

Housing - Community Residence

Improving The Model: Providing greater private accommodation would be an appropriate improvement as it would meet the goal of having a private home and would be consistent with moving toward a model that is "housing" not "facility care".

Actions Required: The Vancouver/Richmond Health Board and BC Housing should work together to explore opportunities to develop models that provide a more appropriate housing environment, based on existing precedents such as the False Creek Residence in Steveston and the Good Samaritan project in Kelowna. This is consistent with the principle of a "most facilitative" model, and of designing housing to maximize autonomy and independence.

Consumers, advocates and disability organizations should ensure consumer representation and participation to contribute to assuring that the model fills current gaps within the continuum of housing and support options. This is consistent with the principle of "nothing about me without me".

Housing - Shared Home/Apartment

Improving The Model: This model has a limited role for a small, specialized potential demand. It would be appropriate for individuals who are unable to direct their own care and require assistance with decision making, but who require less support resources than those in an institutional substitutionary model.

Actions Required: Consumers, advocates and disability organizations should identify if there is a demand for this model and if so, collaborate with the Vancouver/Richmond Health Board and BC Housing to explore the demand and construct a development (housing and supports) that will meet the demand. This is consistent with the principle of providing a range of consumer choice in both housing and support options.

Housing – Clustered Dwellings with Shared Common Areas

Improving The Model: In terms of physical design this model meets many objectives, including integration within a housing context, a smaller scale grouping of residents than the community residence model, and the provision of both a self-contained dwelling and common support amenities.

Currently, capital funding through B.C. Housing excludes the provision of support space and amenities, creating a capital funding shortfall.

Actions Required: The Vancouver/Richmond Health Board, housing providers and disability organizations should explore capital funding strategies for projects in which this housing type is desirable.

Housing – Clustered Dwellings

Improving The Model: In terms of physical design this model meets many objectives, including integration within a housing context, a smaller scale grouping of residents than the community residence model.

This model does not provide shared common areas in order to decrease the capital cost and total area requirements so that it can be built within B.C. Housing funding formulas.

To date, there is only one example of this housing type; which can be combined with three different models of supports. An improvement would be to develop additional sites, consistent with the principle of designing housing to maximize independence and abilities, and providing a range of consumer choices.

Actions Required: The Vancouver/Richmond Health Board, B.C. Housing, housing providers and disability organizations should explore the demand for additional sites, and if demand can be demonstrated, develop additional sites.

Housing – Individual Dwellings

Improving The Model: Wheelchair accessible units are included in virtually all social housing projects. Improvements could include design of the units, and utilization of the units, as discussed under "Housing Barriers and Solutions".

Actions Required: As discussed under "Housing Barriers and Solutions", actions are required by disability organizations and housing providers to educate architects and housing providers, and to build a stronger network linking housing organizations and disability organizations.

Support - Staffed Housing

Improving The Model: This model has limited potential as emerging alternatives are likely to be preferable for this consumer profile, including CSIL and the hybrid supports model. The principle weakness is that there is likely to be limited demand and eligibility for the model. If it can be demonstrated that there is sufficient consumer demand, this model should be replicated, as it does offer the flexibility of support that is both scheduled and on call as needed, combined with the independence and privacy of a private self-contained home and independence from involvement in negotiating or participating in a shared care model.

Actions Required: Consumers, advocates and disability organizations should identify if there is a demand for this model and if so, collaborate with the Vancouver/Richmond Health Board and BC Housing to explore the demand and develop a project (housing and supports) that will meet the demand. This is consistent with the principles of "nothing about me without me", and of providing a range of choices in housing and support options.

Support – Shared Supports

Improving The Model: The supports are linked to the housing and are site based. Staff are unable to leave the housing setting to accompany tenants in their activities of daily living. Modification of the staffing and funding model to provide a hybrid of a base level of support within the housing, shared by all tenants, combined with an individualized level of supports that are provided directly to the tenant, would be a significant improvement to this model as it would allow tenants greater flexibility, autonomy and choice in their activities outside their home and enhanced ability to participate in the community.

This model is unique in that tenants directly manage and direct their own supports on a shared basis. It is this feature that makes the model attractive to many potential residents.

Actions Required: The Vancouver/Richmond Health Board should work with consumers in existing models to explore modification of the staffing and funding model to provide a hybrid of a base level of support within the housing, shared by all tenants, combined with an individualized level of supports that are provided directly to the tenant. This is consistent with the principles of individual integration into the community, and of a "most facilitative" model.

Support – Combined Staffed/Individualized Supports

Improving The Model: This model should be replicated within a social housing model and with varying numbers of tenants sharing supports. This model has the potential to meet a range of consumer housing and support ne ds and preferences, and has not been widely used to date. The amount of staffed supports and the amount of individualized support could both vary considerably based on tenant support requirements and preferences.

Actions Required: The Vancouver/Richmond Health Board, housing providers, and BC Housing should work together with disability organizations and housing providers to identify the number of tenants and the model of supports and to develop specific housing projects based on this model of support. Variations in the level of supports and number of tenants should be explored. This is consistent with the principle of providing a range of consumer choices in both housing and support options.

Consumers, advocates and disability organizations should ensure consumer representation and participation to contribute to assuring that the model fills current gaps within the continuum of housing and support options. This is consistent with the principle of "nothing about me without me".

Support – Individualized Supports

Improving The Model: For consumers whose needs and goals are compatible with this model, the dual challenges are accessing appropriate and affordable housing and securing adequate supports.

The model could be improved by facilitating the provision of supports that are consistent with individual requirements.

Actions Required: The identified improvements and actions required have been addressed in the "Barriers and Solutions" section. The solution recommended is consistent with the principle of providing funding based on individual requirements.

New Models

Improving The Model: While incremental improvements to existing models will improve the range of housing and support options, there are also opportunities to explore and develop new models for housing or supports, and to explore new models based on new combinations of housing and supports.

Few of the models above address the issue of housing tenure identified in the values and principles. When housing and supports are linked, support ineligibility can lead to loss of housing. Models that address this potential issue are one area in which new models could better address the values and principles.

Actions Required: There are opportunities for consumers, advocacy organizations and other stakeholders to work in partnership with the Vancouver/Richmond Health Board and B.C. Housing to explore and develop new models for housing and supports.

HOUSING AND SUPPORTS – IMPLEMENTATION PLAN

This report has identified a continuum of housing and support options, solutions to specific barriers, best practices in the provision of housing and supports, and specific actions required to improve and expand the range of housing and support models.

The Advisory Committee for this report has agreed to continue working collaboratively to address these issues and provide management and support for implementation of the report recommendations.

This section integrates all of these recommendations within an action plan that focuses on four areas:

1. Policy
2. Information and Awareness
3. Additional Housing and Support Capacity
4. Implementation Resources

There are a total of 14 areas for action identified, with specific implementation recommendations for each one. These recommendations for action address the issues identified in this report and move toward achieving the goals, values and principles that have been articulated. Many of these actions require leadership by various stakeholders from the Advisory Committee that contributed to this report.

The areas identified for action are:

Policy

1.0 Changing health care system policies and practices.

Information and Awareness

2.0 Disseminating this document widely.

3.0 Seeking support for the values, principles and best practice policies identified in this report.

4.0 Communicating and information sharing about housing and support options.

5.0 Building relationships between housing providers and housing consumers.

6.0 Designing guidelines for wheelchair accessible and wheelchair adaptable units.

Additional Housing and Support Capacity

7.0 Identifying housing and support needs and preferences.

8.0 Increasing funding for supports.

9.0 Adding resources for transition opportunities.

10.0 Accessing housing subsidies.

11.0 Maintaining and expanding the rent supplement program.

12.0 Targeting new BC Housing developments.

13.0 Targeting private sector housing opportunities.

Implementation Resources

14.0 Adding resources to implement the recommendations.

Policy

1.0 Changing health care system policies and practices.

It is recommended that:

1.1 the Vancouver/Richmond Health Board build ongoing formal communication, liaison and accountability linkages between the health authority and relevant Ministries and agencies that also have funding and service delivery responsibilities.

1.2 the Vancouver/Richmond Health Board develop a formal ongoing role for consultation and inclusion of advocacy and consumer organizations at the policy level.

1.3 the Vancouver/Richmond Health Board develop formal, transparent, comprehensive and equitable guidelines and policies for determining and allocating support funding.

1.4 the Vancouver/Richmond Health Board evaluate the advantages and disadvantages of developing a separate and distinct funding program and model for supports to address the unique and diverse needs of adults (aged 19 to 65) with physical disabilities.

1.5 the Vancouver/Richmond Health Board expand the appeal mechanisms for decisions pertaining to consumer support funding to include an appeal level independent of the Vancouver/Richmond Health Board.

Information and Awareness

2.0 Disseminating this document widely.

It is recommended that:

2.1 the Vancouver/Richmond Health Board, BC Housing, and consumer and advocacy organizations, disseminate this document widely for use as an information, awareness and education resource, and as the basis for action.

3.0 Seeking support for the values, principles and best practice policies identified in this report.

It is recommended that:

3.1 the Vancouver/Richmond Health Board, BC Housing and other Ministries and agencies recognize and support the values, principles and best practices identified in this report, and use them to guide policy and planning decisions related to housing and supports for people with disabilities and the development of future housing and policy documents.

3.2 advocacy and consumer organizations continue ongoing communication and advocacy to increase awareness and acceptance of the principles, values and best practices identified in this report.

4.0 Communicating and information sharing about housing and support options.

It is recommended that:

4.1 the Vancouver/Richmond Health Board, with assistance from consumer and advocacy organizations and BC Housing, develop a booklet for consumers that provides clear and detailed information about the process for securing supports and for securing housing, including the process, policies, guidelines and limitations, and the options that are available.

4.2 the Vancouver/Richmond Health Board ensure inclusion of the information in the booklet on its future web site, and that this be linked to the BC Housing web site.

4.3 the relevant sections of the booklet be included in the BC Housing web site.

4.4 consumer and advocacy organizations actively assist in disseminating the booklet.

5.0 Building relationships between housing providers and housing consumers.

It is recommended that:

5.1 consumer and advocacy organizations work proactively to build relationships with housing organizations, such as the B.C. Non-profit Housing Association, the Co-operative Housing Federation of B.C., and housing providers in the Lower Mainland, particularly the larger organizations which manage many units. Specific strategies may include:

- Establishing a Working Group of housing providers, housing organizations, and consumer and advocacy organizations to exchange information, build awareness, and collaboratively address issues related to matching tenants and housing, and appropriate utilization of units.
- Developing mechanisms to assist housing providers in identifying potential tenants when units are available.
- Preparing communication and awareness resource materials that can be shared with housing providers and housing organizations. Topics for education include: the profile of people with disabilities, the benefits of inclusion in housing, the importance of appropriate design, the importance of location, the issues related to the timing of securing housing, and specific strategies for connecting housing providers and potential tenants.
- Organizing awareness and education sessions and presentations at the annual conferences of the BC Non-profit Housing Association, and the Co-operative Housing Federation of B.C.

5.2 consumer and advocacy organizations establish regular contacts with BC Housing, the BC Non-profit Housing Association, and the Co-operative Housing Federation of B.C to learn about and access information materials on currently available subsidized accessible housing resources and how to effectively access these resources.

5.3 consumer and advocacy organizations assume a leadership role in proactively communicating to consumers about the housing resources that are available and how to effectively utilize them.

6.0 Designing guidelines for wheelchair accessible and wheelchair adaptable units.

It is recommended that:

6.1 consumer and advocacy organizations work with BC Housing staff, including the Director of Client Services, the Director of Development and the Manager of Technical Services, to share information and increase awareness about the changing profile of people with disabilities and their functional requirements related to housing (for example, environmental control systems and wheelchair accessible showers).

6.2 BC Housing consider the issues identified in this report, and consider changes to design guidelines to more appropriately meet the functional requirements of those individuals with physical disabilities who are occupying units, or needing units in Vancouver and Richmond.

Additional Housing and Support Capacity

7.0 Identifying housing and support needs and preferences.

It is recommended that:

7.1 the Vancouver/Richmond Health Board undertake a comprehensive review to identify and quantify the housing and support needs and preferences of individuals with physical disabilities who are currently within the system (including adults under the age of 65 living in residential care facilities).

7.2 For individuals who indicate a preference to live in another community, the Vancouver/Richmond Health Board should encourage other regions to provide appropriate housing and support resources; and advocacy and consumer organizations should work with clients to liaise, negotiate and advocate for appropriate housing and resources in the community of the client's choice.

7.3 the Vancouver/Richmond Health Board utilize the needs analysis information and funding requirements information to identify the level of need for various housing and support models and use this information to guide future housing and support option development.

7.4 the Vancouver/Richmond Health Board work in partnership with BC Housing and housing providers to identify and pursue specific housing development opportunities that could meet the identified housing and support needs.

7.5 the Vancouver/Richmond Health Board, in partnership with consumer and advocacy organizations, evaluate existing support models to determine how well they meet the identified principles and values, to determine the type of adjustments to the model to better meet residents' needs, and the associated costs.

8.0 Increasing funding for supports.

It is recommended that:

8.1 consumer and advocacy organizations continue to advocate to achieve the goal of increased funding for supports, including individualized funding.

9.0 Adding resources for transition opportunities.

It is recommended that:

9.1 the Vancouver/Richmond Health Board, in partnership with George Pearson Centre, G.F. Strong Centre, and all agencies, organizations and stakeholders who are involved in the provision of housing and supports for individuals with physical disabilities, identify and evaluate the types of supports required to effectively support individuals in transition, and the best strategies for funding and providing the required supports. This would be likely to involve new or expanded service delivery, with associated program funding requirements.

10.0 Accessing housing subsidies.

It is recommended that:

10.1 consumer and advocacy organizations meet with the Co-operative Housing Federation of B.C. to initiate discussion and potential resolution of the issues of consumer access to wheelchair accessible units and of providing a subsidy for every wheelchair accessible unit in federal co-ops. Specific potential strategies may include the annual conference and the development and distribution of written materials and resources that can be used as education tools for federal co-ops.

10.2 consumer and advocacy organizations, in partnership with BC Housing, develop and distribute education and awareness resources to housing providers to ensure understanding that in mixed income housing developments, flexibility exists to obtain additional subsidy funds if required for a wheelchair accessible unit.

11.0 Maintaining and expanding the rent supplement program.

It is recommended that:

11.1 consumer and advocacy organizations pursue use of the newly introduced BC Housing rent supplement program, and continue to support and advocate for expansion of the program, particularly in terms of its recognition of people with disabilities.

12.0 Targeting new BC Housing developments.

It is recommended that:

12.1 consumer and advocacy organizations, with assistance from BC Housing, identify and approach housing providers who are developing new housing in the Vancouver/Richmond area to explore opportunities to increase the number of wheelchair accessible units, to ensure that the design is appropriate, and to work with the housing provider to secure those units for people with disabilities.

12.2 the Vancouver/Richmond Health Board work with BC Housing to identify and approach housing providers who are planning developments which would be compatible with combined housing and support models. These projects will likely require some specialized design, and therefore planning needs to be initiated at an early stage of development.

13.0 Targeting private sector housing opportunities.

It is recommended that:

13.1 consumer and advocacy organizations and housing and service providers work proactively to build relationships with private sector developers, educate them about consumer needs, and identify opportunities for public-private partnerships.

13.2 consumer and advocacy organizations explore models and mechanisms for home ownership by individuals with physical disabilities, such as models developed by the developmental disabilities community, specifically Planned Lifetime Advocacy Network (PLAN).

Implementation Resources

14.0 Adding resources to implement the recommendations.

It is recommended that:

14.1 the Vancouver/Richmond Health Board take a key role in proactively linking individuals with physical disabilities to housing and support resources; co-ordinating, overseeing, and liaising with housing/service providers for development, delivery and management of housing and support options. The role includes advocating for policy and practice changes identified in this report and in keeping with the values, principles and best practices.

14.2 consumer and advocacy organizations identify funding sources and seek funding, to support the pursuit of specific initiatives deemed a priority. Consumer and advocacy organizations have a significant role to contribute in achieving these initiatives and will require additional resources to implement these recommendations.

APPENDIX A – VALUES AND PRINCIPLES

1. A range of consumer choices in both housing and support options.

People with disabilities should have a range of both support options and a range of housing options and should be able to make choices based on their unique and different needs. Choices should not be limited by what is available.

2. Individual integration within the community.

People with disabilities should be recognized first and foremost as citizens. Community integration constitutes more than the provision of housing and basic personal care located in the community. Integration includes the ability to participate fully in the social, recreational, educational, employment and other opportunities that provide a quality of life equal to that of a person without disabilities living in the community.

3. "Nothing about me without me": autonomy and self determination in housing and support.

People with disabilities should be respected and involved as participants in all decision making related to their lives, including housing and supports. The capacity for self-determination should be recognized. For those who need assistance with decision making, the individual should determine who will assist them, and those individuals should be enabled to support the person with a disability in decision making.

4. The provision of supports and housing should be based on a "most facilitative" model as opposed to a "least restrictive" model, and should not be dominated by a health care paradigm.

Housing and support choices need to be anchored on the belief that people should not have to live in institutions. Of equal importance, the negative attributes of institutions should not be transferred to housing and supports in the community. The goal should be to think first and foremost of a person's home.

5. Design housing to maximize independence and abilities.

Housing should be designed and built with design and technology features that promote independence and meet the needs of the widest range of people with disabilities.

6. Provide housing tenure.

People with disabilities should enjoy the same security of tenure as people without disabilities and housing tenure should not be dependent on supports.

7. Funding should be based on individual requirements.

Funding should be based on individual requirements. The specific models for the delivery of supports and housing should offer a range of choices.

8. System collaboration and continuity.

There is need for continuity and linkages to allow people with disabilities to move between health regions, between organizations and agencies, and to benefit from the co-operation of various government ministries and programs.

1. A range of consumer choices in both housing and support options.

People with disabilities should have a range of both support options and a range of housing options and should be able to make choices based on their unique and different needs. Choices should not be limited by what is available.

- choice
- choice – a variety of options
- offering choice and a range of options
- people need options – not to be forced into a certain situation because of money
- choice – not being forced into something just because it's available
- no one solution – don't deny opportunity to make choices
- plan and offer a range of choices, many different kinds of housing
- need full range of options
- no perfect recipe that fits for everybody
- don't jump on the flavour of the month (right now it's "shared care")

2. Individual integration within the community.

People with disabilities should be recognized first and foremost as citizens. Community integration constitutes more than the provision of housing and basic personal care located in the community. Integration includes the ability to participate fully in the social, recreational, educational, employment and other opportunities that provide a quality of life equal to that of a person without disabilities living in the community.

- integration (not segregation or warehousing)
- community awareness and support
- diversity – don't want to live in a group home that is only people with MS
- integration
- concerned when we think we're going a good thing by assisting people to move into the community but really we're moving the institution to the community
- need to assist people to have what's needed to further their desire to contribute
- maximize independence – not just basic physical care, also quality of life and assistance outside the home (social, recreational, employment, school, errands, groceries, appointments) assisting person to participate in the community rather than being restricted to being at home
- respecting a person's ability to direct their life to their potential – if they need assistance it should be available, so that each person's abilities are recognized and maximized
- quality of life – recognizing person, not just physical needs, all too often only look at personal care
- put the person first – work around that person's needs – care, housing, transportation
- integration is key
- that it include more than basic ADL, include whole life, not a medical model
- avoid clustering by disability – need to promote social integration, real and normal roles rather than perpetuating the consumer/client role
- capacity to contribute to society depends on supports
- recognize the value of home support and the difference it can make in a person's life
- services should be flexible and provide quality of life similar to people in the community
- make all units so you can visit any unit
- have housing with a mixed population: kids, old people, people with disabilities, everyone
- building should be integrated

3. "Nothing about me without me": autonomy and self determination in housing and support.

People with disabilities should be respected and involved as participants in all decision making related to their lives, including housing and supports. The capacity for self-determination should be recognized. For those who need assistance with decision making, the individual should determine who will assist them, and those individuals should be enabled to support the person with a disability in decision making.

- participation of people with disabilities in the process itself
- the involvement of people to define their access needs – design
- honouring self determination to the extent that a person is capable, and where they're not capable, enabling their advocates
- self-directedness
- autonomy
- clients, wherever possible, should be in control
- "society is as strong as it treats its most vulnerable members"
- consumer driven
- involve person in all decision making
- encourage self-determination
- "nothing about me without me"
- need the person with the disability to be the one leading it all, including planning
- person with disability should determine who assists with decision making if needed
- that the individual is involved in the plan
- consumer driven
- anchored on self determination
- first and foremost people are individuals; not all people with disabilities are the same, can't fit round pegs into square holes
- recognize that self-determination be overriding principle
- independence
- as independent as possible
- person with disability is in charge, is respected by staff, provides direction
- maximizing the tenant/client/consumer input into all phases: planning, development, operation, governance
- minimizing professional control of people's lives
- have to move away from assumption of independence being the goal for everybody – need to recognize that many people will need ongoing supports and assistance lifelong
- case managers assess risk, patronizing model, lack of consumer power – client should have the right to assess, take risks
- with any option, need to look at who controls and who makes the decisions
- power intrinsic in relationships – need correct balance of consumer control
- want management to be done by the person living there or by the person they choose
- have rights and responsibilities to make their own decisions wherever possible
- right of self determination
- individual is own advocate and should have control over all decision making in own home

4. The provision of supports and housing should be based on a "most facilitative" model as opposed to a "least restrictive" model, and should not be dominated by a health care paradigm.

Housing and support choices need to be anchored on the belief that people should not have to live in institutions. Of equal importance, the negative attributes of institutions should not be transferred to housing and supports in the community. The goal should be to think first and foremost of a person's home.

- people should live in the least restrictive environments - institutionalization should be a last resort.
- commitment to deinstitutionalization – working from the belief that people shouldn't live in institutions
- people end up having to be grouped together – important that not focus on that because it's a mini-institution (unless two people choose to live together)
- a lot of times end up in shared care
- think first and foremost of a person's home not a model of a residential treatment centre or something that is an efficient place for health care practitioners to practice their craft
- don't want it to be dominated by a health care paradigm
- shift thinking from "least restrictive care model" to "most facilitative model"
- institutionalization should be a last resort – need other alternatives
- need to see place as individual's own home

5. Design housing to maximize independence and abilities.

Housing should be designed and built with design and technology features that promote independence and meet the needs of the widest range of people with disabilities.

- physical accessibility
- physical accessibility
- provide supports to allow people to function at highest level
- supporting independence, an independent support
- housing – maximize independence e.g. automatic doors, to make it so a person doesn't have to struggle, build to worst possible scenario, to maximize independence
- well designed to promote independence
- to be able to adapt design as needs change
- privacy
- privacy
- physical design should be at highest level to provide optimum functioning – architectural and technical design

6. Provide housing tenure.

People with disabilities should enjoy the same security of tenure as people without disabilities and housing tenure should not be dependent on supports.

- security of tenure
- housing tenure
- housing should be tenured
- support services should be separate from tenancy

7. Funding should be based on individual requirements.

Funding should be based on individual requirements. The specific models for the delivery of supports and housing should offer a range of choices.

- individualized funding
- support can be a bigger issue than housing – can get by with not-so-great-housing but can't get by with not-so-great care
- assistance attached to individual, not building – enables person to be mobile
- housing should be kept separate from support – two very different things
- that it be individualized and flexible
- need to recognize that although supportive housing is attractive, shouldn't always link supports and housing
- principle should be that funding for supports tied to individual, not housing
- ideal is to tie funding to the individual
- need to address all three in conjunction: housing, supports, and relationship between housing and supports
- need supports for transition, but don't necessarily specifically need housing for it
- supports available as needed

8. System collaboration and continuity.

There is need for continuity and linkages to allow people with disabilities to move between health regions, between organizations and agencies, and to benefit from the co-operation of various government ministries and programs.

- partnership – government ministries, community groups, health organizations working together to assure the best model
- collaboration between ministries
- need for systemic supports – case management
- need freedom of movement
- don't want a single point of entry/control mechanism that determines who gets what in terms of housing and supports. consumers need choices, is not consistent with "community", encourage many possibilities, many client options, can have own ways of doing intake
- security of funding/supports – has to be cross-regional to allow mobility
- funding should be attached to individual, not region

APPENDIX B – BARRIERS IDENTIFIED BY STAKEHOLDERS

Lack of availability of existing wheelchair accessible housing

- need wheelchair accessible units
- lack of wheelchair accessible housing
- lack of inventory of wheelchair accessible housing
- difficulty of locating wheelchair accessible housing – no way of knowing if it is available
- wheelchair accessible units not always occupied by people with physical disabilities
- some buildings opposed to disabled tenants or they select tenant who nominally meets criteria e.g. wheelchair accessible unit given to a person with arthritis in their hands
- co-ops have become a barrier – not as open to housing people with disabilities as they should be - don't get word out, may not want to accommodate, i.e. refuse to install power door openers, not as aware and accommodating
- many wheelchair accessible units not occupied by people in wheelchairs – how do we access these units?
- amount of accessible housing
- people in charge of housing may not be committed to housing people with disabilities – discrimination, attitudes, lack of education
- not a lot of housing resources or information about housing
- lack of wheelchair accessible housing
- lack of community support, resistance to having a particular type of housing in a neighbourhood
- lack of clarity around housing subsidy for tenants with a live in attendant
- availability of accessible housing
- need accessible housing for families and couples, not just singles
- accessibility of units can be problematic – i.e. lack of power door openers, no wheelchair accessible shower
- non-disabled people are housed in wheelchair accessible units
- some housing has been designated as accessible but isn't
- lack of awareness of available housing
- too often wheelchair accessible units are filled by able bodied people because it's faster and easier
- BC Housing not useful at all
- have built housing resources but are not able to access them due to lack of awareness
- long waiting lists for housing
- not enough wheelchair accessible housing
- lack of places to go
- can be problems with people who need two bedrooms for live in support
- housing funds aren't available or aren't being channelled to projects for people with disabilities
- wheelchair accessible units don't seem to get used to provide a supported environment – units get built, but Housing and Health aren't communicating

Design of wheelchair accessible housing

- question "accessibility" of available housing
- some wheelchair accessible housing isn't
- available housing can be inadequate in terms of wheelchair accessibility
- accessibility of the housing – "wheelchair accessible housing" often isn't e.g. has a bathtub
- design is not always adequate
- need showers that are wheelchair accessible
- make housing easy to get around – automatic doors
- if elevator breaks down there is no other exit
- elevator buttons can be a problem, horizontal ones are best
- need more wheelchair accessible showers, most places have bathtubs

Affordability of housing/unavailability of subsidies

- housing is not affordable if on GAIN
- affordability of housing
- funding for the housing – subsidy not always available, especially in co-ops
- funding for housing

Difficulty moving between health regions

- regionalization has exacerbated the ability to move from one area to another
- can't take CSIL to another region
- regionalization has caused barriers to moving between regions –can't transfer hours, have to re-negotiate, discrimination against mobility rights, may not be able to live in preferred location, may be isolated from supports and in wrong community
- when move from region to region, policies change – inequitable. Other regions allow less hours – most people choose Vancouver. Mobility restrictions. Even if you change CHA, you may be re-assessed and risk having hours cut

Funding and timing of securing housing, support, and equipment

- timing and co-ordination – when a housing opportunity comes up, need to be able to co-ordinate the supports, and the equipment quickly before the housing opportunity is lost
- equipment barriers – need track lifts, power door openers and can't apply until you have an address, takes 3-4 weeks to obtain funds, then time to obtain and install equipment
- lack of provision for equipment
- environmental control systems are a key [electronic controls for opening doors, blinds, using telephone, computer, television, stereo, etc.]
- equipment such as door openers, track lifts, is not funded
- timing – getting all the pieces together at the right time, especially attendant care – can find housing but care is not in place and then risk losing housing – is an inhibitor to good integration back into the community, clients start falling into dependency

Inadequate support funding

- need adequate home support – hours are being reduced
- disturbing that people are expected to be alone at night
- fear of funding authorities forcing shared care if move into a building with other people with disabilities, which has [allegedly] occurred – tenants pressured by Continuing Care
- trend is for financial efficiency to become the default, reducing choice
- can't get enough support hours to be able to maintain independent or semi-independent living
- a project with two or three wheelchair accessible housing units isn't enough to create a supportive model
- has to be co-ordination around support services – need economy of scale
- funding for support and care
- most people don't have enough hours
- need funding
- competing with demands of aging population – concept of finite care resources
- attitude of Continuing Care case managers that "you're taking away from others"
- government cutbacks to health care, beds, home support, rehab
- trend toward fewer services (supports and care)
- fear of loss of flexibility due to Continuing Care changes
- loss of options and choices with fewer service providers
- biggest barrier for Pearson residents is number of hours of support made available
- support too limited to allow people in institutions to live in the community
- majority now living at Pearson have some form of cognitive impairment
- lack of availability of rehab services
- need availability of nursing services for people who are medically fragile
- primary barrier is attendant care hours
- issues with degenerative diagnoses, tendency is to institutionalize
- very hard to separate housing issues from care issues
- confining if attendant care isn't attached to person (e.g. at Noble House staff cannot leave) - people are living in the community but they can't go out of their own homes
- person becomes isolated, may as well be in an institution as in the community if they don't have the supports to go out
- when you're forced to share care, get only basic needs met, no time for extra things
- six is too many people to live together and not enough care is available.
- with CSIL hiring attendants is sometimes an ordeal, sometimes very difficult to find attendants, hard to retain attendants, high turnover because asking people to work 24 hours and be paid for 8
- agencies have a lot of rules and regulations, may send someone who is unfamiliar, end up training constantly, if hire own staff can have more flexibility
- number of hours available are not enough, especially for somebody needing 24 hour assistance
- home support may be too limited to allow community participation
- funding

- resistance to recognizing the value and financial sense of individualized funding
- there doesn't seem to be a model to support younger to middle aged adults – too much is borrowed from geriatrics (such as homemaker support) and too much emphasis is on costs and on meeting only basic needs - could improve health and capacity to contribute (earn incomes, get off GAIN) if didn't scrimp on care
- people in own apartments get too socially isolated because of lack of supports to go out

Location of housing: transportation, amenities, safety

- community, neighbourhood – needs to be near transportation, amenities so you can get out and do things, needs to feel like a safe and secure neighbourhood
- location of housing – transportation is a major issue, limited wheelchair accessible housing on accessible transit routes
- safety is an issue, many people with disabilities feel more vulnerable
- location – need to be near amenities, transit
- transportation – easier to live independently if it's available
- if you can't handle transportation independently, you're pretty stuck – many people need to be accompanied by an attendant
- lack of day activities
- transportation

Bureaucracy/Paternalism

- single point of access/gatekeeper – control of information and choices
- inhibition of creativity – resistance to untested ideas
- holding too tenaciously to old ideas
- lack of using true community – capitalize on desire to contribute
- type of housing and supports can inhibit rather than facilitate community integration
- rigid rules, bureaucracy
- lack of knowledge on the part of Housing and Health about what is needed
- there are very limited housing and care options
- resistance to innovative and creative options, need acceptance
- paternalism, failure to include people with disabilities themselves
- recognize individual's right to live own lifestyle
- recognize it is client's own home, not agency's home
- always a conflict when other people involved in your life (values, liability, practices, control) – need to retain client's capacity for control
- co-ordinating services among agencies
- no fluid method of assessing and placing people appropriately
- societal barriers – population is not politically powerful and there are professional biases re. quality of life

APPENDIX C – SOLUTIONS IDENTIFIED BY STAKEHOLDERS

Lack of availability of existing wheelchair accessible housing

- need an inventory of wheelchair accessible housing
- clients should have a say in management and operation of the building
- need wheelchair accessible housing registry
- new accessible housing options
- address shortage of beds – create settings where people can live independently
- need to bridge gap between housing that's available and those who need it
- need to work more closely with co-ops
- need more education, PR campaign, positive theme
- better communications, network when units are available, lots of ways to do that
- look at how we can develop new housing
- encourage BC Housing to do more integrated housing e.g. Steveston
- V/RHB should do an evaluation of Steveston to determine if provide quality support more efficiently
- need housing subsidy attached to wheelchair accessible unit
- criteria for tenancy in wheelchair accessible unit should be that one occupant uses a wheelchair
- build more affordable, wheelchair accessible housing
- more co-op housing
- having appropriate facilities to re-locate people to
- need an infrastructure with funding and care

Design of wheelchair accessible housing

- self-contained apartments: privacy, flexibility
- building design standards e.g. larger windows, able to get out onto balcony
- housing that is as barrier free as possible
- look at housing, flexibility, what's being provided, how it's being provided, upgrading some units
- universal design – e.g. automatic door openers
- greater awareness on the part of architects and builders
- universal design so there's always units available - so every single unit is accessible
- education – PR campaign to builders, designers, so many easy ways of doing things accessible
- building code and inspectors – no penalty if not to code
- when making wheelchair accessible units, need to make it so it can be easily changed – e.g. tub/shower
- solution is funding available for all renovations (RRAP often not available), even to new units and need funding fast
- new projects need wheel-in showers

Affordability of housing/unavailability of subsidies

- homeowner's grant – need a tax credit like seniors get
- residents should pay their own rent directly instead of cheque coming from Ministry
- ability for home ownership – e.g. co-housing
- need to find more creative ways of financing housing e.g. some V/RHB initiatives on the Downtown Eastside
- creating housing stock other than the traditional BC Housing model
- need "small is beautiful", innovative, creative approach
- partnerships with landowners
- need leadership to make that happen
- V/RHB and BC Housing need to communicate closely, process should be in place
- V/RHB needs to have some control over the housing
- V/RHB has to be flexible in its models

Difficulty moving between health regions

- CSIL should be a provincial program with individual portability, equality in all regions, freedom of movement

Funding and timing of securing housing, support, and equipment

- timing of supports – can't get money until you have an address
- need to co-ordinate timing: need to acquire support funding and housing at the same time – need up to two or three months to get care, equipment and housing all co-ordinated
- housing providers should hold units until tenants are all organized to move
- equipment – start process earlier, need funds available to be able to implement immediately when housing is secured
- need people in the community that can help fast track the whole transition from institution to home – furniture, equipment, housing, care
- more realistic funding and timeframes to get people into their own homes
- equipment provision
- getting clients the equipment and teaching them the techniques
- providing appropriate assessment, rehabilitation, and discharge planning

Inadequate support funding

- additional funding to meet care needs
- there should be a policy of allowing those who choose, to live in the community, and the financial means should be provided
- funding should be attached to individual not to region
- people should have choice of CSIL
- home support should not be means tested
- increase allotment of support hours
- recognition that attendants need to accompany people to do activities in the community
- change in mindset of decision makers about what "care" is – quality of life
- tie institutional funding to residents and let them move out
- more funding for attendant care
- care attached to person, not the housing
- care – look at range of options, flexibility
- CSIL has really opened the doors to flexible arrangements
- models all over the place pioneered by the developmental disabilities advocates
- increase attendant hours
- defined funding envelopes to eliminate the competition for finite resources ("you're taking away from care for seniors")
- additional funding for care and supports
- funds need to be available to assist person who needs support
- greater knowledge by Health and Housing about what is needed
- having a staff person on call and able to go out, instead of restricted to the building
- cluster housing and use pagers to reach staff
- linking support funding to individuals, not housing, clients should not be "locked in" by care needs, situation can change: may want to move, have relationships
- somebody needs to co-ordinate and control and manage a shared care model – tenants need support to do it
- ideal is 24 hour on-call staffing combined with primary caregivers selected by tenants
- explore individualized funding
- provide the right amount of supports so that a person's well-being is managed – explore volunteer involvement in a person's life
- more funding is needed for home support (big cutbacks in 1994)
- housing providers should commit to not being involved in care e.g. St. George's
- need to clarify issue re live-in attendant and rent subsidy
- having more funding for people who need assistance with decision making
- smaller shared care situations for those who need (people who are basically independent but need care available but not full time attendants) or prefer them
- cost comparisons of models needed (Pearson at $400-$500 per diem)
- need rehab and nursing at home
- needs to be an acknowledgement that people with complex care needs require greater case management even for people who can self-direct. Need flexibility, capacity to respond to changing situations

- commitment systematically to deinstitutionalization
- need to get away from congregate care – Noble House and Steveston are better, City Club units are all on different floors. Too many units in a building is a problem e.g. Kelly Court
- spending health care funds more efficiently
- addressing needs of all areas: rehab, bed dilemma
- provide more housing and care choices
- be in control of own home and of own life
- staff must understand that client is in charge
- need an integrated and diverse community
- smaller group of five or three, or cluster several groups within a larger complex
- true community integration requires the type of housing and supports that will facilitate that kind of relationship
- need a sense of community otherwise people with disabilities can be isolated

Location of housing: transportation, amenities, safety

- more wheelchair accessible stops and routes for buses (like in Seattle)
- 90% of HandyDart should be privatized
- working on inter-connected issues such as transportation
- need to do better with transportation – so intrinsic to housing, HandyDart now so overbooked, can transportation be part of housing? need to think creatively
- take into account needs for transportation and a safe community

Bureaucracy/Paternalism

- for person to be supported in developing own goals
- for person to be encouraged to develop mental and physical functioning
- client should hire and fire agency – client in control and seen by staff as in control
- more Ministry of Health and Ministry for Children and Families collaboration for those with both physical and developmental disabilities
- need partnerships between Ministries, including Ministry of Health, Ministry for Children and Families, Ministry of Social Development and Economic Security, and Housing)
- working more collaboratively with organizations, community groups
- multiple points of entry into system
- acceptance, embracing creative options
- increased community supports e.g. IF, CSIL, CARMA
- being willing to listen to stakeholders
- education and awareness of information and choices
- creativity, embracing untested ideas
- capitalize on consumer contributions to define and reach solutions
- need more information and advocacy resources

APPENDIX D – PROJECT PROFILES

Stanley Noble Stronge Housing Co-operative

Project Name and Location: Stanley Noble Stronge Housing Co-operative. 730 West 6th Avenue, Vancouver.

Profile of Organization: The housing project operates as a co-operative. The tenants with disabilities have a contract with the B.C. Paraplegic Association for support and assistance with managing their shared care model.

Capital Funding: B.C. Housing provided capital funding.

Operational Funding: Vancouver/Richmond Health Board provides an annual budget of $595,600. This budget is fixed and is based on initial negotiations and assessment of the original tenants. Of the original seven tenants, three still living there; two moved out on CSIL and three died.

Per diem costs (housing and supports): Rents are geared to income per B.C. Housing operating agreements, and all tenants are on GAIN. The supports cost $229.44/per diem. Tenants also pay $150/month toward shared groceries and cleaning and household supplies. Tenants share in menu planning. The annual housing subsidy from BC Housing is $163,337.

Description of Housing: The project is a four storey building with an interior courtyard. There are a total of 21 units of family housing. Of the 21 units, seven wheelchair accessible units are located on the third floor and are clustered around the building's common area, which functions as the dining room, kitchen and staff space for the seven residents with physical disabilities.

Specific Accessible Features: The seven wheelchair accessible units were designed for people with significant physical disabilities. Bathrooms are very large, and have either a tub which can accommodate a lift, or a wheelchair accessible shower. The bedrooms have a large sliding wall which can be retracted to open the bedroom to the living areas. Windows are low to enhance views from a seated position. The unit layouts are open and efficient to facilitate movement and circulation. All seven units have numerous features that can be operated by infrared technology, including automatic door openers, opening and closing curtains, answering the telephone, and using the entertainment equipment. All building doors and elevators have infrared operating capability. The central common area, located on the floor with the seven accessible units, is a vital feature.

# of Units/People with Disabilities: Seven of the 21 units.

Tenant Profile: All tenants in the seven accessible units have significant physical disabilities, including ventilator dependence, and require access to 24 hour care. The other units accommodate low income families and single adults.

Operating Model/Provision of Supports: Staff are available on a 24 hour basis. There are two to three staff on during the day and evening and there are two staff on at night, although one is a sleepover shift. Staff are a combination of home support workers and LPN's.

Linkage Between Supports and Housing: The support model is linked to the housing. B.C. Paraplegic Association was essential in establishing the support model and maintains a critical role in the ongoing operations. While tenants are responsible for managing and training staff, the B.C. P.A. provides support and assistance to tenants, and is also responsible for some management co-ordination and communications functions related to waitlisting, policies and procedures, standards and negotiation and monitoring of agreements.

Philosophy and Values: Clients should be in control to the greatest extent possible. Is tenant's home, not caregiver's workplace. Integration. Right of self determination, including right to make lifestyle choices including risks.

Best Practices: Deinstitutionalization of tenants who previously had no option other than institutional care. Tenants hire, direct and manage staff. Because it is a co-op, tenants have security of tenure.

Blair Court

Project Name and Location: Blair Court, 2060 West 10th Avenue, Vancouver.

Profile of Organization: Vancouver Resource Society operates Blair Court. Vancouver Resource Society was founded in 1972 to provide affordable, accessible housing for people with physical disabilities. Currently, the Society manages 18 group homes, and three apartment buildings in Vancouver and Burnaby.

Capital Funding: Provided through B.C. Housing.

Operational Funding: Provided by Vancouver/Richmond Health Board. Total of $500,000/year for 12 people.

Per diem costs (housing and supports): Because the project is social housing, units are subsidized at varying levels. Subsidized rents range from $229 to $875. The per diem cost of the supports is $112. BC Housing funds an annual subsidy for the housing of $281,152.

Description of Housing: There are 39 units of housing, comprising one, two and three bedroom units. Of the total units, 20 accommodate people with disabilities. 12 tenants with disabilities access the on site support services, another eight tenants with disabilities live in the building but do not use the support services. The self contained apartments are designed to be wheelchair accessible in accordance with B.C. Housing guidelines.

Specific Accessible Features: Automatic door opener at building entrance. 11' high underground parking to accommodate adapted vans, access to all units, no threshold at balcony doors.

# of Units/People with Disabilities: About 20 of the 39 units include a person with a disability in the household.

Tenant Profile: About half the tenants do not have disabilities but require affordable housing. Tenants with disabilities who use the on site support are require an average of 4.5 to 6.0 hours of care each day. All tenants must be able to direct and manage their own care.

Operating Model/Provision of Supports: The staffing is a total of 8.4 FTE. There is at least one person on at all times, and depending on peak service times, there may be up to four staff available.

Linkage Between Supports and Housing: The provision of supports is linked to the housing and does not vary. Potential tenants with disabilities must be able to have their needs met within the available support staffing model.

Philosophy and Values: To develop innovative models of housing and support that provide affordability, accessibility, integration into the community, and the ability for clients to achieve their potential for self-directed and independent living.

Best Practices: Staff are available and on call 24 hours/day but are not in tenants' private units. Tenants with disabilities may obtain housing only or may obtain on-site support services in addition to housing. Convenient, accessible, safe location.

St. George's Place

Project Name and Location: St. George's Place, 2950 Laurel Street, Vancouver.

Profile of Organization: St. George's Place Society is a housing operator; this is the only project that the Society is involved with. The Society was formed by St. George's Anglican Church and B.C. Rehabilitation Foundation.

Capital Funding: St. George's Anglican Church has leased the land to the Society for $1 for 60 years. Funding was provided by B.C. Housing to build the building, which includes 19 units of social housing and a multipurpose/worship space and church amenity and office space.

Operational Funding: The housing operating budget, including rent subsidies, is fully funded by B.C. Housing. The annual subsidy is $123,617,

Per diem costs (housing and supports): Rents range from low end of market to core need subsidy. The cost of supports is individualized and funded to tenants directly.

Description of Housing: There are 19 one, two, three and four bedroom units which are wheelchair accessible or adaptable, as per B.C. Housing guidelines.

Specific Accessible Features: All units have dishwashers. There are infrared remote controls on all common doors, and the elevator. Some tenants have installed automatic door openers on their units. All common areas are fully wheelchair accessible.

# of Units/People with Disabilities: There are a total of 19 units. At this time, there are eight tenants who have physical disabilities and use wheelchairs. Some other tenants have various disabilities, but do not use wheelchairs.

Tenant Profile: Tenants range from toddlers to the elderly. There are several families, some couples, and some single adults. Some individuals with disabilities live with their families, some live with caregivers, and some live alone.

Operating Model/Provision of Supports: The housing model is a standard B.C. Housing operating model. The Society has no role in the provision of supports.

Linkage Between Supports and Housing: The provision of supports is linked to the individual tenant and not to the housing. Two units are rented by the Society to the Victorian Order of Nurses (VON) which manages the suites as transition units for people returning to the community following rehabilitation.

Philosophy and Values: As part of its mission, St. George's Place Society is responsible for ensuring that the tenant selection process continues to reflect the vision and mission of the partners in creating housing for people with disabilities.

Best Practices: Board commitment to creating and maintaining a respectful, inclusive and caring housing community. Continuing to ensure that the housing accommodates people with disabilities. Formal recognition in the mission statement that: "As part of its mission, St. George's Place Society will limit its role to housing and will respect the unabridged right and responsibility of tenants to independently arrange, manage and control their own care and support in the form of their choice. Any such care and support will be tenant based, not site based. The Society may choose to endorse the provision of such services by other service providers who wish to operate within the building if the Society agrees that such programs are consistent with the mission."

False Creek Residence – Steveston Project

Project Name and Location: 11119 No. 1 Road, Richmond.

Profile of Organization: The project has been developed and will be operated by False Creek Residence Society. There is a property manager for all property management services. Since 1979, False Creek Residence Society has operated a 24 bed licensed facility for adults with physical and developmental disabilities in the False Creek neighbourhood of Vancouver.

Capital Funding: Capital funding was provided through B.C. Housing. The land was provided by the City of Richmond at no cost to the Society for a 60 year lease. Funds were donated for the therapeutic tub and the Society funded the call system, medical equipment for tenants and the kitchen equipment.

Operational Funding: Operational funding is being provided through Richmond Health Services. The current budget is $500,000 per year to be negotiated based on union contracts. BC Housing provides an annual subsidy of $281,188.

Per diem costs (housing and supports): The housing is all mixed income and all tenants pay rents geared to income. Eight of the ten current tenants in the units with supports are on B.C. Benefits and pay a monthly rent of $200. The cost of supports is $136.99 per diem. This level of funding was based on an equivalency to individuals on CSIL funded for five to six hours of daily support. Tenants also contribute to the costs of the shared food and non-health supports: their contributions are pro-rated based on the long term care client cost contribution formula. For clients on B.C. Benefits, the rate is $11.25 per diem or $342 per month.

Description of Housing: The building has a total of 20 units of one to three bedroom family housing. Of the total, 10 units are fully wheelchair accessible one bedroom units which have tenants who need the available supports. In addition to the self contained units, the common space includes a large kitchen for daily meals, a dining/lounge area, a specialized therapeutic tub room, and a staff office. The kitchen and dining area is the located at the heart of the building and contributes to creating a sense of community in the building.

Specific Accessible Features: The entire building and outdoor area is wheelchair accessible. Within the units, the bathrooms have wheelchair accessible showers, counters and storage at the sink and access on both sides of the toilet. The kitchens have a full size refrigerator, single sink, dishwasher, cooktop and a microwave. There is a wired in space for an oven if tenants wish to purchase one. Each unit has a washer and dryer. The emphasis is on the provision of amenities tenants need for privacy, independence and dignity (laundry, functional bathroom). The kitchen/dining area is more limited because there is a central dining area and meals are part of the support program. The common space includes a therapeutic tub with a lift.

# of Units/People with Disabilities: Total of 10 people with disabilities supported by False Creek Residence Society. The remaining ten units include one wheelchair accessible two bedroom unit.

Tenant Profile: The tenants all have heavy care needs and are assessed at an IC3 or extended care level. Some are moving from long term care facilities. The majority have acquired, not congenital disabilities, such as multiple sclerosis, strokes, and other disabling conditions. Some tenants have disability related cognitive impairments and deterioration. Most tenants benefit from support and assistance with planning and organizational skills and safety.

Operating Model/Provision of Supports: The program of support is licensed in order to meet risk management and quality assurance requirements. There is a full time tenant care manager who is a registered nurse, and 7.3 FTE tenant support staff. There are two staff on during the daytime and one staff person at night. There is also 1.75 cooking staff who provide three meals daily, and 0.5 recreation co-ordinator.

Linkage Between Supports and Housing: The staffing model is linked to the housing.

Philosophy and Values: Tenants of False Creek were encouraged and assisted to participate in the planning and development of the project, which is based on recognizing and meeting the goals of the tenants. False Creek Residence Society recognizes that supports must be individualized and based on an individual's whole life, not just basic activities of daily living. People are encouraged to do what they can for themselves.

Best Practices: The 10 units are integrated throughout the building. There is generous provision of both personal space and amenities in the units, and shared common space and amenities. Operating model emphasizes trained and qualified staff who possess good communication skills, understand infection control, respect the tenants' expertise and preferences for care, and have a clear understanding of professional boundaries. Philosophy of supporting involvement of family and friends, and integration into the community. Value of volunteers in addition to paid staff as a means of encouraging people to thrive.

GVMHS/Katherine Sanford Project

Project Name and Location: 561 East 16th Avenue, Vancouver

Profile of Organization: The project is a partnership between two organizations: Katherine Sanford Housing Society and Portland Hotel Society. Katherine Sanford Housing Society is the developer and property manager; Portland Hotel Society is the operator and provides the support services. Both organizations are involved in multiple projects.

Capital Funding: The land was purchased by the City of Vancouver and leased to Katherine Sanford Society at 75% of market value for a 60 year lease. The capital costs were funded by B.C. Housing according to MUP guidelines, an additional $100,000 was required because of the small project scale.

Operational Funding: Provided through mental health services of the Health Board. BC Housing provides an annual subsidy of $182,578.

Per diem costs (housing and supports): Tenants pay $325/month for rent and there is a subsidy of approximately $700 per month for each unit. The funding for program services (support staffing) averages to a per diem of $29.32 (total annual budget of $192,634). .

Description of Housing: A four storey building set in a residential neighbourhood. The building has 18 self contained small studio units, with kitchens (two burner cooktop, sink, microwave, and below counter refrigerator), bathrooms, and a living/sleeping area. Some have fold down Murphy beds. Common space includes an office near the front door, a kitchen (tenants must be accompanied by staff), a dining/activity space, washroom, a smoking/TV lounge, and a lounge/TV/laundry area. Outdoor space includes a large patio area with some garden space around it.

Specific Accessible Features: The project included an elevator although it was expensive and many projects of that scale do not have an elevator. Fully wheelchair accessible throughout the building.

# of Units/People with Disabilities: There are 18 single occupancy units. One unit is wheelchair accessible. The current tenant of that unit does not use a wheelchair, but has significant mobility impairments and may use a wheelchair in the future.

Tenant Profile: All tenants have a mental illness and may have other conditions. Tenants are those who cannot successfully live independently, even with a SuperSIL program, but who do not want to live in a controlled, licensed setting and want as much independence as possible. Tenants need support available. Tenants are people who were difficult to place and had a poor housing history.

Operating Model/Provision of Supports: Although the building would ideally be staffed 24 hours, staff are present from 9:00 a.m. to 10:30 p.m. There are three staff: a co-ordinator, mental health worker, and a cook/mental health worker. The number of staff working varies from one to three, depending on the time of day. On weekends, there is only one person working. The primary role of staff is to ensure that tenants have comfort, safety and respect. Staff are available to meet tenants' needs without creating an institutional environment and without being in the tenants' units. This model safeguards against isolation and the associated risks of decompensation and suicide. Staff also liaise with the community mental health team. Dinner is provided daily, and tenants pay $1.50 for it if they want it.

Linkage Between Supports and Housing: All the supports are linked to the housing. The homemaker support is currently linked to the tenant, but will likely soon be block funded and linked to the housing program.

Philosophy and Values: To provide a stable housing choice for a population that has difficulty achieving that goal. To have basic respect for the tenants and the lives that they lead. To develop the programs and services that are required to ensure the comfort and safety of tenants. Partnerships with other service providers. To ensure quality housing, and a physical environment that is pleasant. To provide tenants with choices and options that ensure there are only good outcomes.

Best Practices: No eviction policy. Partnerships with other service providers based on respective expertise. Non-institutional model: to provide tenants with positive choices and options, and to combat isolation. To ensure quality housing, and a physical environment that is pleasant. Consumer driven design (e.g. kitchen area defined and separated, elevator, frost free refrigerators) that communicates respect for tenants.

Millennium Place

Project Name and Location: Millennium Place, 3655 Clark Drive, Vancouver

Profile of Organization: Millennium Place is operated by the Lions Paralodge Society, which is a partnership of the B.C. Paraplegic Association and the Vancouver South Lions Club.

Capital Funding: The project was a re-development of an existing site, so the land was already owned by the Society. Capital funding was based on the MUP (Maximum Unit Price) allocation from B.C. Housing.

Operational Funding: By choice, there is no operational funding for supports other than the operations and management of the housing component.

Per diem costs (housing and supports): Rents are geared to income, per the BC Housing formula. Some tenants receive subsidies. BC Housing provides an annual subsidy of $358,492.

Description of Housing: Total of 39 units. All units are accessible or adaptable. There are some furnished transition units designed for quadriplegics. The units are organized in pairs with a "swing" bedroom between each pair so that it can convert from a one bedroom to a two bedroom unit, and to allow for a range of care and support options.

Specific Accessible Features: The units are generous in size, which enhances accessibility. Many units include ceiling track lifts between the bedroom and the bathroom. There are infrared controls for all common doors, elevators, and some unit entrances. Most units have wheelchair accessible in-suite laundry.

# of Units/People with Disabilities: Of the total tenants, 23 have a physical disability.

Tenant Profile: All tenants with physical disabilities arrange their own care, independently of the housing.

Operating Model/Provision of Supports: None.

Linkage Between Supports and Housing: None.

Philosophy and Values: The Society made a conscious decision not to develop a care model linked to the housing. The Society determined that the most appropriate solution was that the care be attached to the individual instead of the building as this allows more client mobility and portability of supports.

Best Practices: Comprehensive design review at final design stage to optimize wheelchair accessible design features. Provision of transition units. Formal Board decision that supports should be linked to individual, not housing.

City Club

Project Name and Location: City Club, 7077 Beresford Street, Burnaby

Profile of Organization: Community Living Society was incorporated in 1978 to facilitate the movement of individuals from institutional living to community living. From then, it has grown to become a major service provider with 45 residential sites and seven vocational programs. Clients have developmental and physical disabilities.

Capital Funding: The project was developed without public funding. The private sector developer, in partnership with CLS, obtained a 25% density bonus on the site from the City of Burnaby. In return, CLS got 10 wheelchair accessible units for $40,000 per unit.

Operational Funding: Operational funding is provided by Ministry for Children and Families through several contracts for the individuals living at City Club.

Per diem costs (housing and supports): Monthly rent is based on income. Monthly strata fee for each unit. Support costs not available.

Description of Housing: Ten self contained wheelchair accessible one bedroom and one bedroom plus den apartments. One per floor in the first ten floors of a market housing project that has low rise housing, commercial development at grade and over twenty storeys of highrise apartments in one tower.

Specific Accessible Features: The accessibility features were specified by CLS and include large, wheelchair accessible bathrooms, balcony doors that open automatically in case of a fire, and refuge areas on each floor.

# of Units/People with Disabilities: There is one person with a disability residing in each of the ten units.

Tenant Profile: Most tenants are significantly disabled and need access to support 24 hours. Most are non-verbal and could not independently direct their own care.

Operating Model/Provision of Supports: Tenants have a range of housing and support options. Some of the tenants rent their housing from CLS but require no supports. Some have supports provided by another agency during the day, but using the CLS overnight staffing. Some tenants have 6 to 12 hours of staffing provided by CLS during the day, and at night there is one staff person on call for all tenants who need overnight on call staffing.

Linkage Between Supports and Housing: The staffing model would be adjusted with a change in tenants. Contracts are individualized so a tenant could move out and take their MCF funding and contract to another agency. There is one contract for the overnight support, and there are individual contracts for the clients that CLS provides daytime support to.

Philosophy and Values: The mission of CLS is to support each individual to live with dignity and to thrive as a fully participating citizen within their community. The Society values the intrinsic worth of each unique individual, honours their autonomy and works with them to build from strengths.

Best Practices: Combines a full range of housing and support options for tenants. Integration in market housing with units physically separated. Combines optimal independence and privacy with 24 hour support.

Mill Woods Centre

Project Name and Location: Mill Woods Centre, 101 Youville Drive East, Edmonton, Alberta

Profile of Organization: Is operated by the Good Samaritan Society, a Lutheran social service organization that has served the elderly and disabled for over 50 years. They operate four assisted living facilities, one Alzheimer cottage site, two independent housing projects, and four continuing care facilities. They also operate a range of support programs, services for persons with developmental disabilities, support groups and volunteer and pastoral services. All programs are in Alberta; there is one assisted living project currently being developed in partnership with B.C. Housing in Kelowna.

Capital Funding: The capital funding for Mill Woods Centre was provided entirely by Good Samaritan Society using donations and the revenue from the resident fees.

Operational Funding: The resident fees cover all "room and board" services including meals, housekeeping, laundry and rent. There is additional direct funding from the health region for residents' personal care.

Per diem costs (housing and supports): The tenants pay a basic fee of $875/month ($28.76/day) for room and board including one meal a day. For breakfast and lunch, for laundry service, or for housekeeping more than once a week there are additional fees of up to a total of $115/month. The cost of personal care (funded directly by health region) was not provided, but is greater than $66/day (the rate for Wedman House which is a lower level of care).

Description of Housing: There are 60 bachelor units, grouped in two areas of 30. One area is for people with physical disabilities, one area is for people with respiratory needs, including 15 people on ventilators. Each area has a central courtyard. The units are 420 square feet, with bathrooms with wheelchair accessible showers and kitchenettes (cooktop, bar refrigerator, sink, counter and cupboards). For the respiratory unit, most bathrooms have tubs, some rooms have track lifts, and some rooms have piped in oxygen. None of the resident units have any infrared controls, including power door openers ("caregiver will help" a respirator dependent tenant open the door). There is a call system in each room. Spouses may live with tenant, for an additional $400/month. A third central courtyard is accessed from the central dining room area. There is one central lounge, entrance area, and office areas, including a medication room, reception and staff office.

Specific Accessible Features: Power door openers on all common doors, no stairs or ramps, wide hallways and doorways. Concrete pathways and raised planters in courtyards.

# of Units/People with Disabilities: There are a total of 60 units; all are occupied by people with disabilities.

Tenant Profile: Program is for adults under 65 and tenants range in age from early 20's to 60's. Tenants age in place, although if their decision making capacity is compromised, the model of care may not be appropriate and they may need to move because of risk management issues.

Operating Model/Provision of Supports: The operating model is "assisted living" and is a substitutionary model for licensed facility care. The key factors that differentiate it are: negotiated service agreements based on tenants' needs and choices, and managed risk agreements that are negotiated when tenants choose to forego services or make lifestyle choices that result in risks.

Linkage Between Supports and Housing: Supports are linked to the housing, not the individual.

Philosophy and Values: A unique alternative to facility care, based on a social (not medical) model of care. Assisted Living offers a home-like, residential experience for people who desire privacy and maximum involvement in decision making.

Best Practices: Substitutionary model for facility care.

Bloomfield Gardens

Project Name and Location: Bloomfield Gardens at 41st and Oak Street in Vancouver.

Profile of Organization: Vancouver Resource Society owns and manages six units in the 35 unit private sector market housing project. Vancouver Resource Society was founded in 1972 to provide affordable, accessible housing for people with physical disabilities. Currently, the Society manages 18 group homes, and three apartment buildings in Vancouver and Burnaby.

Capital Funding: Vancouver Resource Society financed the project directly, based on a recovery through the rent to cover the mortgage. The Society purchased six of the units at a fixed price, prior to project development. The City granted the project a density bonus which was used to offset the capital costs to the Society. The savings were equivalent to the land value component of the six units, which were purchased for construction costs only.

Operational Funding: All tenants are on the CSIL program. Tenants contribute 1 hour/day of their hours to VRS, which manages a shared care model of on call staff 8 hours/day (overnight coverage). Tenants manage their remaining hours directly, hiring their own staff or working with the agency of their choice. In addition to the six units owned by VRS, there are two other units in the building which are rented by WCB clients who participate in the shared care model.

Per diem costs (housing and supports): Rents range from $325 to $1,200 per month. VRS is the landlord and co-ordinates the agency contract for the support services, which are provided by another agency.

Description of Housing: The four storey project is a typical market condominium project. The six units are located on the first two floors. Each unit, while compact, has full amenities, including wheelchair accessible shower, full kitchen appliances, and a gas fireplace. Unit finishes are of a higher standard than that of social housing.

Specific Accessible Features: The building entrance has an automatic door opener. The six VRS units have standard wheelchair accessible design features.

# of Units/People with Disabilities: The building accommodates six people with physical disabilities in units owned by VRS. Some other units also accommodate people with disabilities.

Tenant Profile: Tenants are all capable of directing their own care. Most have significant physical disabilities and require access to 24 hour care.

Operating Model/Provision of Supports: The shared care model is designed to provide a staff person who is on call for the eight hour overnight shift. Additionally, clients co-operate with each other, and because they have their own staff during other hours, if there is an emergency and somebody needs help they have neighbours they can call on 24 hours.

Linkage Between Supports and Housing: Prospective tenants must agree to participate in the shared care 8 hour support model.

Philosophy and Values: To develop innovative models of housing and support that provide affordability, accessibility, integration into the community, and the ability for clients to achieve their potential for self-directed and independent living.

Best Practices: Hybrid model of shared care and individualized supports in which tenants may choose their own staff and schedule care to meet their needs, while also obtaining overnight coverage. Integration with private sector market housing. Housing development without public funding.

Rotary House

Project Name and Location: Rotary House, 5861 Hardwick Street, Burnaby

Profile of Organization: Vancouver Resource Society operates Rotary House. Vancouver Resource Society was founded in 1972 to provide affordable, accessible housing for people with physical disabilities. Currently, the Society manages 18 group homes, and three apartment buildings in Vancouver and Burnaby.

Capital Funding: Provided by B.C. Housing, land leased from the City of Burnaby for $1. Rotary Club donated capital for a van and some equipment.

Operational Funding: The annual operating budget of $512,000 is funded by the Simon Fraser Health Region.

Per diem costs (housing and supports): The per diem cost of the supports is $280. Additionally, tenants pay 30% of their GAIN income for rent, and contribute $125/month toward food and operating costs for the house.

Description of Housing: The group home is a spacious, single storey ranch style house that is fully wheelchair accessible. It was built in 1994.

Specific Accessible Features: Ceiling track lifts, therapeutic tub.

# of Units/People with Disabilities: Total of five clients, all of whom have disabilities.

Tenant Profile: Most tenants have multiple sclerosis. Tenants have significant physical disabilities and their conditions may deteriorate. Tenants are supported at all stages, including end-of-life care. They are not relocated due to increasing care needs unless the client is at risk. The level of care includes feeding tubes and home IV, palliative care.

Operating Model/Provision of Supports: Total 8.56 FTE including 0.5 RN and 1.0 Supervisor (LPN).

Linkage Between Supports and Housing: The operational model is linked to the housing.

Philosophy and Values: To develop innovative models of housing and support that provide affordability, accessibility, integration into the community, and the ability for clients to achieve their potential for self-directed and independent living. For this project, provision of care until not medically possible, and a no-discharge policy unless the client is at risk.

Best Practices: Provision of care at all levels required, including extended care and end-of-life.

Choices in Supports for Independent Living (CSIL) Model Profile

Program Name: CSIL (Choice in Supports for Independent Living)

Profile of Organization: The CSIL began as a provincial Ministry of Health program. The program is currently funded by regional health boards.

Capital Funding: No housing component.

Operational Funding: Each client is assessed and assigned a number of hours of support per day, based on their individual requirements. Clients may be re-assessed if their requirements change. The model client profiled is funded to receive eight hours of support daily ($200 per diem).

Per diem costs: Funding is at $25 per hour (based on the fees paid by the health board to home care agencies). CSIL clients range from about four to 12 hours of support daily.

Description of Housing: Tenants on CSIL are responsible for finding their own housing separately from the CSIL support funding program, which has no housing component. The model client lives in a subsidized unit in a co-op. The person lived there, and was supported by a home care agency, prior to going on the CSIL program.

Specific Accessible Features: Not applicable.

# of Units/People with Disabilities: Most people on CSIL live in their own apartments. In a few cases, CSIL clients live together to pool their hours, and in one case (Bloomfield Gardens) CSIL clients pay one hour of support as a contribution to the overnight coverage.

Tenant Profile: Varies. The model client is a high lesion quadriplegic and requires access to support 24 hours. The client lived at Pearson until 1976, and in a group home from then to 1986 when the client moved into the housing co-op and received agency support. In 1994 the client went on the CSIL program.

Operating Model/Provision of Supports: Each person on CSIL is provided with direct, individualized funding and is responsible for directly managing their own care. Clients may spend up to $100 per month of their allocated funding on administrative support services, including the costs of staff recruitment, payroll, and bookkeeping. Clients may also use funds to purchase services from an agency. Clients are responsible for all aspects of recruiting and hiring staff, training staff, scheduling and managing staff, and paying employment income, including calculations of all deductions and benefits.

Many clients on CSIL stretch their funding to cover more than the assessed hours, especially clients who require access to care for extended periods. Some CSIL clients have their staff live with them, and include room and board as part of the compensation package. The model client, who is allocated eight hours per day, has 24 hour staffing, although some staff take a four hour break during their shift. The model client pays $160 for a 24 hour shift, which includes sleeping over. (The remaining $40 of the per diem is to cover benefits and relief). When the model client was with an agency, there was 24 hour staffing.

The model client has a total of three staff – one works four days per week and the other three work one day per week. CSIL clients have a range of staffing arrangements. The model client is very positive about CSIL and says "everything is good". Advantages cited included flexibility, along with the ability to control staff recruitment and training. Other clients have indicated that the program is very positive, but that the negatives include inadequate or inequitable assessments of hours of daily support, the challenges of recruiting and retaining staff, and finding qualified or appropriate staff.

Linkage Between Supports and Housing: None. Clients can take their CSIL funding with them when they move within the health region. If clients move between health regions, they must re-negotiate to obtain CSIL funding from the region they plan to re-locate to.

Philosophy and Values: The CSIL program emerged as a response to consumer demands.

Best Practices: The CSIL program is based on individual funding principles, and allows maximum individual autonomy in the provision of supports.

Client Support Group Model Profile

Program Name: Client Support Group model.

Profile of Program: The Client Support Group is a complement to the CSIL program and allows clients who are unable to direct their own care, which is one of the criteria for CSIL, to participate in CSIL with the support of a formally incorporated group of client representatives. The client support group must be a registered non-profit society. The society must have five directors, each of whom commits to participate for at least two years. Following official registration, only three out of the five are required to carry out the day to day responsibilities of the society. Relatives, friends, neighbours, the family physician, and others are all eligible to be directors of the society. Family members may not be paid workers, nor are directors paid for their time. Each client support group may be responsible for only one client. While client involvement is encouraged, the client support group is responsible as the employer of all home support workers and is responsible for all management, recruitment, training, scheduling, payment and supervision of staff; bookkeeping; compliance with Revenue Canada, Workers' Compensation Board, Employment Standards Act, and other regulatory requirements; and insurance.

Capital Funding: No capital or housing component. Is separate from program and is responsibility of client. In the case of the model client profiled, the client returned to live at home with a spouse following a CVA and a period of time in an extended care facility.

Operational Funding: The funding for support and care is provided directly from the Health Board to the Client Support Group. Funding is allocated based on an assessed number of hours, the same as for other CSIL clients.

Per diem costs (housing and supports): Varies depending on the number of hours. Payment is $25 per hour of care funded.

Description of Housing: Client's original home. Spouse has made some adaptations to make it safer and more accessible for the client.

Specific Accessible Features: Not applicable.

# of Units/People with Disabilities: In the case profiled, the model client lives with a spouse, and home support workers come to the home during the daytime.

Tenant Profile: The model client is aged 47 and had a CVA (stroke). The client is able to walk short distances with a cane or handrails, but uses a wheelchair outside for longer distances due to fatigue. The client has ongoing concerns with confusion, dysphagia, depression, ataxia, cognitive decline and peripheral blindness. Indications are that the client is benefiting from being at home relative to behaviour in the extended care facility.

Operating Model/Provision of Supports: For the model client profiled, the spouse provides support during the evening, night and weekend hours. Friends provide relief during weekend day hours and one night per week. Staff are hired to provide weekday assistance and supervision.

Linkage Between Supports and Housing: None.

Philosophy and Values: Recognition of family and friends as capable of managing client's best interests.

Best Practices: Formal empowerment of family and friends to manage client's care and support. Expansion of direct funding model to clients who are unable to direct their own care.

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